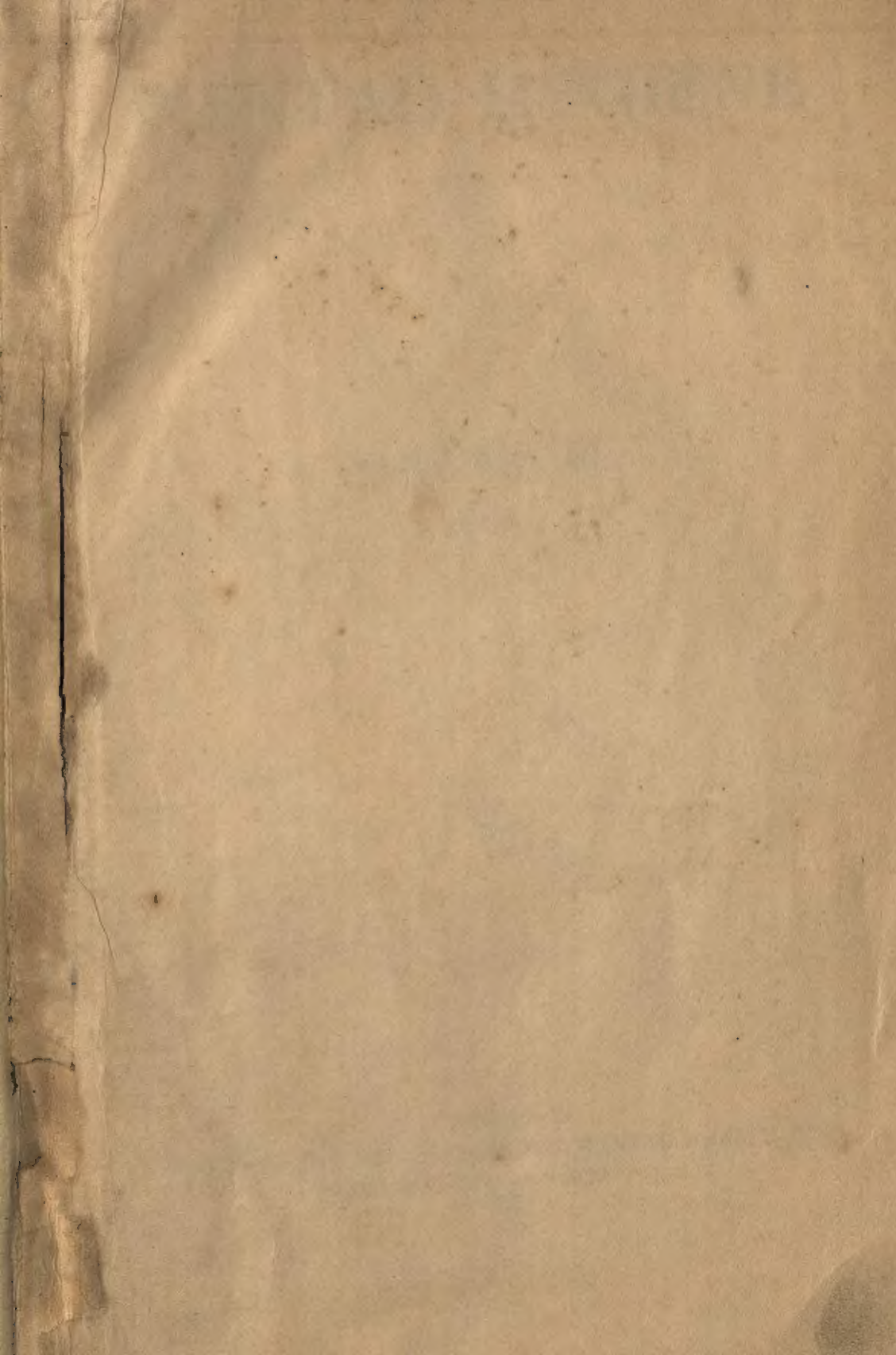


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The National Association for Mental Health, Inc.

*The Voluntary Promotional Agency of the
Mental Hygiene Movement*

Founded by Clifford W. Beers

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The National Association for Mental Health is a voluntary organization working for the promotion of mental health; for the prevention of mental and nervous disorders; for the improved care and treatment of the mentally ill; and for the special training and supervision of the mentally deficient.

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ORIGINAL CONTRIBUTIONS AND BOOK REVIEWS

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MENTAL HYGIENE

VOL. XL

JANUARY, 1956

No. 1

MENTAL HEALTH AND ILLNESS * THE NATIONAL PICTURE

DANIEL BLAIN, M.D.

Medical Director, American Psychiatric Association

MENTAL Health Week is rapidly becoming a recognized institution throughout all the states. In many state capitals this week and next, citizens from every walk of life are expressing their interest in one of the most baffling of the health problems of the nation—the mental illnesses. This meeting is a tribute to the mental hygiene movement starting with Clifford Beers in 1908 and long nurtured by the National Committee for Mental Hygiene (now the National Association for Mental Health) and by Dr. George S. Stevenson, its leading spokesman for these many years.

All states have their ups and downs. Periods of intensive effort, with legislative and administrative backing, have given hope at times. Just now, we find great hope in the renewed life and vigor that present leaders are imparting to the state program. In Pennsylvania, for example, backed by his Excellency the Governor, the Secretary of Welfare, the Honorable Harry Shapiro, is launching a new effort which, judging from the start that has been made, will give the mentally ill in Pennsylvania markedly improved status. With the help of the newly formed advisory committee, it appears that political and professional leadership and support are available and will be ingeniously applied. The legislature has from time to time appropriated increased funds, and I am told that the sum of money available for operation of mental institutions has been tripled — going from \$30,000,000 in 1944 to nearly \$90,000,000 at this time.

Yet, in spite of some splendid new buildings here and there,

* Address presented at the Mental Health Week rally held in Harrisburg, Pa., April 28, 1955, by Pennsylvania Mental Health, Inc.

there are still overcrowding, shortage of staff, low discharge rates, and failure to keep up with the pressure of new admissions. Statistically, the size of the problem has not diminished since 1944, though I am sure there are some qualitative gains. Thus, if increased expenditures have essentially failed to make a real dent on the problem, it remains to discover just what has been missing in the development of the program over the last ten years, and this I am sure can be done. But first, let's look at the national picture.

"Some 750,000 mentally ill and retarded patients are now being hospitalized on any given day.

"Forty-seven percent of the hospital beds in the nation are occupied by mental patients.

"The direct economic cost of mental illness to the taxpayers of the nation, including pensions to veterans with psychiatric disabilities, is over \$1,000,000,000 a year and has been increasing at the rate of \$100,000,000 a year.

"The emotional impact and distress suffered by millions of our people anxiously and justifiably concerned about the welfare, treatment, and prospects of mentally afflicted relatives is incalculable and is one of the most urgent concerns of our people.

"The governors of the several states, through national and regional governors' conferences and through the publications of the Council of State Governments, have shown great initiative in their cooperative attempts to develop better methods of meeting the challenge of mental illness in their states.

"There is strong justification for believing that this constantly growing burden may well be due primarily to an outmoded reliance on simple custodial care in mental hospitals as the chief method of dealing with mental illness.

"There is strong reason to believe that lack of early intensive treatment facilities has created such a backlog of mentally deteriorated patients that it has become virtually impossible for the states to meet the need for mental hospital facilities.

"There is strong reason to believe that one of the greatest impediments to more rapid progress in the field of mental health is a definite shortage of professional personnel in all categories.

"There seems to be a discouraging lag between the discovery of new knowledge and skills in treating mental illness

and their widespread application, as is evidenced by the fact that whereas only about one-third of newly admitted mental patients are discharged from state hospitals in the course of a year, in a few outstanding institutions the recovery rate is 75 percent or more.

"Experience with certain community out-patient clinics and rehabilitation centers would seem to indicate that many mental patients could be better treated on an out-patient basis at much lower cost than by a hospital.

"There is strong reason to believe that a substantial proportion of public mental hospital facilities are being utilized for the care of elderly persons who could be better cared for and receive better treatment in modified facilities at lower cost" (provided these simplified housing arrangements are under proper administrative and professional control).

"There is reason to believe that many emotionally disturbed children are being placed in mental hospitals, which have no proper facilities to administer to their needs.

"Mental illness is frequently a component of such nationwide problems as alcoholism, drug addiction, juvenile delinquency, broken homes, school failures, absenteeism and job maladjustment in industry, suicide, and similar problems.

"There seems to be no overall integrated body of knowledge concerning all aspects of the present status of our resources, methods, and practices for diagnosing, treating, caring for, and rehabilitating the mentally ill, although only through the development of such a body of knowledge can the people of the United States ascertain the true nature of this staggering problem and develop more effective plans to meet it.

"By supporting enormous capital investment in new mental hospital construction, the American people have demonstrated their growing understanding of the economic and social cost of mental illness, and their willingness to sacrifice to overcome it."

It may be surprising to state that all of the above statements are quoted from a legislative proposal now (1955) before Congress. This proposal (Joint Resolution 256), in which we all have a stake, would make funds available for a national study of all aspects of our present methods and practices for diagnosing, caring for, and rehabilitating the mentally ill. It

has already passed the House of Representatives and may pass the Senate any day now.*

It was Dr. Kenneth E. Appel who first conceived and formulated the idea of the need for such a national study about two years ago when he was president of the American Psychiatric Association. In his own words, Dr. Appel has stated:

Planning on a nationwide, long-term scale is essential. A commission should be established to study current conditions and develop a national mental health program. Patchwork, stop-gap programs are keeping us on a treadmill and actually doing little or nothing to reduce and prevent mental illness. We resign ourselves to needless suffering and to the waste of money and human resources, instead of taking action. Mental illness is not a parochial problem. It must be attacked on a national scale. Psychiatrists should be leaders in this attack. We can contribute much in experience and insights. We should enlist the collaboration of all other professional groups that are concerned with the medical and social aspects of mental illness and mental health.

Now Dr. Appel's original conception has become the common property of all of us to whom this national problem has been of such deep concern these many years past.

The happy fact of the matter is that we are in the midst of an unprecedented national concern and determination to do something about the massive problem of mental illnesses. The governors have made their concern crystal clear in their national and regional conferences. In the Congress, the joint resolution I mentioned was sponsored by 42 senators from both political parties. Legislatures by the score throughout the 48 states are falling in with the new spirit that something can and must be done about this great problem beyond providing minimal custodial care for the mentally ill, and in many states (though not all) the legislators have already substantially increased their appropriations for mental health.

Popular radio and television stars are coming to us asking how they can help. One of our famous baseball players, in one of our great popular magazines, has told how he had been taken mentally ill, hospitalized, and recovered. The famed Dr. Jonas Salk and his associates have pegged mental illness as the next great medical problem (after polio) that should occupy our national attention.

* Joint Resolution 256 became Public Law 182 of the 84th Congress on July 28, 1955, when it was signed by President Eisenhower after passing both houses of Congress without a dissenting vote.

So I say we are on the threshold of a new era in our struggle to cope with this great problem. And it is particularly pertinent at this time to let Shakespeare remind us that "there is a tide in the affairs of men, which, taken at the flood, leads on to fortune," for there seems every likelihood that in the climate of good will in which we now find ourselves we may discover the wherewithal to launch a far more fundamental attack on mental illness than has ever before been feasible.

What is to be done? In what direction should we go? Our first thoughts, of course, must focus on the patients in the hospitals. By way of dramatic emphasis, I might point out that at the moment there are plans in eight states that I know of to spend \$950,000,000 for new construction of mental hospital facilities, and this in spite of the fact that in no instance are any existing public hospitals sufficiently staffed to take full advantage of the relatively meager knowledge we now have.

Nevertheless, there are many encouraging things and some rather astounding successes in our hospitals which most of us know little about. Two or three of the illnesses related to brain damage have been essentially conquered, such as general paresis, which at one time accounted for ten percent or more of our patients. Outside of our hospitals, few people realize the tremendous increase of activity potential in those states which used to be ridden by hookworm disease and which are now relatively free of it. This is the disease which caused so much apathy, weariness, lack of initiative, and frequently a complete destruction of motivation to succeed in life, to take care of one's family, to make anything out of life.

Now also we have come to understand the role vitamins play in pellagra, which has so often masqueraded as "senile psychosis" in our mental hospitals.

In another group of patients, which might almost be said to include at least one in every family, we find the so-called "middle-age reaction," which in its extreme form is known as involutional melancholia. Now the treatment of this disease is almost as successful as penicillin has been for pneumonia. Except in cases where there is a serious overlay of other conditions, the patient with middle-age depression, who used to take two to three years to treat under the best of conditions,

now frequently leaves the hospital in two or three weeks. A member of my own family was cured in eleven days.

Another most remarkable thing is that an ever greater number of patients with serious mental illness are now being taken care of in out-patient clinics, and often they continue to assume responsibility in the family and on the job while they are undergoing treatment. In other words, hospitalization for many of the seriously ill is frequently unnecessary. I suggest that *this factor of what can be accomplished outside the mental hospital is the most important single thing we should study and carry to its utmost logical conclusion.* When community services are available, many patients can be kept out of hospitals. Many patients can get out of hospitals far sooner than they otherwise could. And many of those who come out need never return to the hospital again.

I want to describe briefly a general concept of an overall community approach to the mental illness problem which is understood quite widely abroad but has not as yet been introduced to any substantial extent in the United States. I refer to the concept of the "mental health community center."

The mental health center was described and carefully worked out by representatives of ten nations, from all continents, at a meeting of the World Health Organization in 1952 in Geneva, Switzerland. I found later on that an article on the same general subject had been published in the *New York Times* by Dr. George S. Stevenson, of the National Committee for Mental Hygiene, in 1948.

A mental health center can be adapted to the needs of any community or region of a state. In effect, it is an organization under responsible leadership, designed to unite the resources of the state program with the efforts of private practitioners in the community, including the various specialties, professional people in the school system, industry, the public health department (particularly public health nurses), social agencies, etc.

Let me try to paint a picture of how such a center is operating in one place in England. There is only one in England—and it is there not because of the special medical plan there but because of the leadership of one individual, Dr. T. P. Rees, who is unique in his imagination, his organizing ability,

his feeling of public service, and in his faith in mental patients and in their relatives.

There is a mental hospital nearby, but Dr. Rees spends a good deal of his time as director of the Mental Health Center. This includes an out-patient clinic to take care of those living at home. He had a group of doctors, nurses, social workers, and others, some of whom work in the mental hospital part of the time but who are rotated through the mental health center to give part of their time to the community service. Dr. Rees works with a group of specialists in psychiatry who are doing private practice and makes use of their services, part-time in the clinic and part-time as private practitioners. He hears about people becoming ill and sends a team into the home to see what they need and to assist in finding out the *simplest* form of service that would take care of them. (What a contrast is this to what we usually do! As soon as someone becomes ill, our first step is to send him immediately to a mental hospital.) Some of Dr. Rees' staff also rotate in looking after the psychiatric unit of a general hospital nearby.

In this mental health center there are clubs for people who have been mental hospital patients but who are now living at home and can come in for social life. A good deal of group therapy goes on in the main building of the center. A number of older people who are not sick or broken down come in for various activities, occupational therapy work, and general preventive services which help keep them on their feet and in circulation. A number of crippled people of various types also come there to participate in various activities to see how life can be made more useful to them. A well-baby clinic and a child guidance clinic are available for both children and parents.

In general, there is an *organized pulling together* of all the resources in the community, to the total effect that a population of 250,000 people is easily taken care of in a community where the hospital alone has only 1,000 beds. And these 1,000 beds are largely for patients who have been there for many years and who did not have the advantages of early treatment through the mental hospital center. The newly sick patients are mostly taken care of in the community itself.

The experience of Dr. Rees suggests in a dramatic way

that the ideal community must make available a network of services to deal efficiently with its mental health and illness problems, as exemplified by this mental health center. The essential ingredients are *home care, private individual attention, visiting nurses, teams to visit those who cannot be reached by general practitioners, psychiatric units in a general hospital, out-patient services for children and their parents*, and in the background a *regular mental hospital* for the limited number of patients who cannot be cared for at home and who may be sent to the hospital for a short time.

The implication of all this is that in looking to the future we need to de-emphasize our traditional reliance on the mental hospital as an almost exclusive tool for dealing with the mentally ill, and rather think of it as merely one part of a network of community services, all of them designed to forestall hospitalization if possible, and, if not, to make duration of stay in the hospital as short as possible.

I wonder to what extent we appreciate the thought that services in the community are equally valuable to the services of hospitals. The Commissioner of Mental Hygiene of a great state was present when I was making some remarks like these before his advisory council and he said, "We have been doing that for a long time." I said, "Do you really believe community services are as important as hospital services?" "Certainly we do," he assured me. "Well," I said, "would you approve of doubling the budget of your hospitals and spending an equal amount in the communities? Would you put \$140,000,000 into community services? Because that's what you're spending now in hospitalization with little effect." That was a rather staggering suggestion, but that state has only this year put \$15,000,000 into community services. What would Pennsylvania think of putting \$90,000,000 into the budget for hospitals and an additional \$90,000,000 for community services? That amount—\$90,000,000—can be eaten up overnight in operating buildings which, without staffs, can get nowhere so far as reducing the number of patients is concerned. Is it so fantastic and unrealistic to suggest that the same amount of money invested in the kind of community services I have spoken of would pay much greater dividends in the long run?

In one state where I was recently a consultant in making a

survey of its mental health resources and needs, we found that there was apparently no recourse except to build another \$35,000,000 hospital. Yet the survey committee, at my urging, recommended delaying it for the time being and recommended putting an additional \$3,000,000 a year at the disposal of the Department of Mental Hygiene to create community services—in fact, to create one mental health center, as I described it above, and see whether or not it would be possible to avoid the building of a \$35,000,000 institution. With this money, the department could study the problem of personnel, create large sums for research, finance many out-patient clinical services, and give money to the universities, the schools of nursing, the departments of psychology, the departments of medicine, and the schools of social work and occupational therapy to increase their staffs and take over responsibility for training in all the state institutions.

There are many things one can do with money. It is easy to get it for buildings; it is very hard to get it for anything else. What I suggest is that more money be spent on experimental and pilot projects with adjunctive and modified types of hospital and community facilities which may be demonstrated to be effective in forestalling, preventing, or shortening hospitalization. Such facilities are variously called branch hospitals for the aged, day hospitals, night hospitals, halfway houses, mental health centers, rehabilitation centers, and the like. They are essentially modifications and expansion of the mental health clinic idea. Experimentation with these types of facilities has been going on in a few places, chiefly outside the United States, with some indication of success. They represent new and promising approaches.

Let me say also that there is no doubt in my mind that through administrative experimentation we can discover ways of using our present personnel more efficiently. It is my observation in my travels that highly trained key personnel in the hospitals are performing functions and duties which they would like to delegate to less highly trained personnel if a method for doing so could be worked out. There is a tendency to confuse the rôle of top-level leadership on the one hand with operational and technical performance on the other. Hospital administration is hampered by traditional and rigid

conceptions of personnel policies. I am certain that administrative experimentation will show ways of breaking through these barriers, thereby releasing more personnel time for the benefit of the patients.

What are the practical steps that should be undertaken at this time? I can suggest one or two. The first is amplifying and refining the information now in existence—and I would say that a good deal of data in a sketchy sort of way is available in the states. A number of very good studies have been made lately, but they do not go far enough. The American Psychiatric Association has recently been invited by a number of states to come in and assist them in making a comprehensive survey of their total needs and total resources for dealing with mental illness and health. Our survey technique considers 13 different categories of approach to the problems, of which the mental hospitals are only one. Due attention is paid to the relative rôles and responsibilities of federal, state, county, and city authorities as well as private organizations and professional people in private practice.

Indeed, in our state survey work we have to some extent outlined an approach which should be useful as a precedent for the national survey now contemplated under Congressional legislation. A basic assumption underlying the national survey is that out of it will evolve some fundamental new departures from our traditional concepts and methods of dealing with mental illness and that it will lead to a far more effective attack on the problem than has thus far been realized. There is crying need to reexamine our basic assumptions in the field; to see what actually takes place in hospitals with high discharge rates as compared to others with low discharge rates; to assess the factors which account for the tragic lag between the development of psychiatric knowledge and its application in public mental hospitals; to determine the extent to which community services pay off in keeping people out of mental hospitals; to discover the most effective ways of utilizing present personnel; to find out more about the epidemiology of mental illness; to discover why it is that young professional students resist entering the field of mental illness; to find out exactly what our personnel needs are; to review our whole statistical system for gathering data on mental illness; to assess the contribution psychiatry can make to the various

social ills in which mental illness is a component, such as alcoholism, drug addiction, juvenile delinquency and crime, broken homes, school failures, misfits in industry, accident proneness on the highway, suicides, and so on.

But, of course, the findings of the national survey will not be available for the next three or four years, and in the meantime it is important for the several states to push ahead with their own programs and to capitalize to the utmost on prevailing public enthusiasm and good will to get things done.

Perhaps the greatest single need, from the standpoint of organization, would be for the state Mental Health Associations, assisted by other citizens groups, to proceed as fast as possible to organize effectively in various communities and counties, so that their fund-raising campaign may be worked out in detail and carried out with the greatest possible dispatch. How are we going to appeal to people to give us money? How can we convince people that their gifts will have real meaning and benefit for *their* communities?

Certainly you can ask for money for research, for this money can be used wherever research people are available, and there are plenty of such people who can carry out not only basic research but also a broader type of research involving various types of community studies.

You can raise money for community clinical services. I believe it is possible to sell people in every state on the need for services, or child guidance clinics, or a referral center, or a screening facility in their area. It is true that manpower is short. But it is also true that there are many people available on a part-time basis and that a small amount of work started locally usually increases the number of people available as time goes on. I was struck by what happened in Kentucky, where we are now making a survey. In one remote place the only person interested in this entire field—in the absence of any local mental hygiene organization—was a part-time psychologist assigned by the State Department of Mental Hygiene to western Kentucky. He was able to visit this particular town only on rare occasions. Nevertheless, his influence was soon felt and he got the community to discussing and thinking about their local needs. A great deal has since

come out of the very small bit of clinical services which he could personally provide.

I think also you can appeal to people to give money to set up administrative offices in different localities with part-time or full-time executive officers whose business is to get around and study the community's needs and put the people who need help in touch with those who can do something for them, even though they may have to be referred to a distant hospital. This person could organize the interest of people and carry on a continuous effort to work with the medical profession and the nursing group, with people in the courts, in the schools and colleges, and in industry and labor. Such might be the beginning step in the development of a mental health center.

No one knows better than I that fund-raising in this field is a difficult proposition, and the job is not made easier because we deal with a field which has always been mysterious and frightening to the layman. As we survey the tremendous job to be done and the intricate pattern of life into which new-born babies, children, adolescents, and adults now have to live, the tremendous burden of hospitalization to the taxpayer, the lack of scientific data about some of our major mental illnesses, the great stumbling block of personnel shortages, and the like, it is hard not to get discouraged.

I would like to quote a friend we all know, Dr. Alan Gregg of the Rockefeller Foundation, from a speech he made in London in 1948 at the first meeting of the World Federation for Mental Health:

At the dedication of the 200-inch telescope on Mount Palomar in 1948 the guests were allowed to look at a star never seen by man before—a star whose light has been on its swift way hither at 186,000 miles a second for 195,000,000 years—a star which could not receive today's sunlight until the year 195,001,948, A.D. One of the speakers on this occasion, Raymond Fosdick, was tempted to recall the story of the little girl whose version of the nursery rhyme was "Twinkle, twinkle, little star, how you wonder what I are!" The perspective of human life and individual importance in such a matrix of space and time might make us wince. But Mr. Fosdick reminded his audience that although the philosopher may say, "Astronomically speaking, man is completely negligible," the psychologist can reply, "Astronomically speaking, man is the astronomer." And in that heartening answer lie the consolation and the glory of those who study the mind and spirit of man.

STATES ASTIR AGAINST MENTAL DISEASE *

ALBERT DEUTSCH

I HAVE been witness to many changes in the mental health movement since I entered it through the back door of history exactly twenty years ago, when the late Clifford W. Beers generously got me a grant that made possible the preparation of my history of the care and treatment of the mentally ill in America. Since then, as social historian and journalist, I have made the rounds of more than sixty mental hospitals and numerous mental clinics, together with many centers of psychiatric research and training. Having surveyed the field vertically and horizontally, and having noted periods of inspiring progress alternating with heartbreaking retrogression, I now feel no hesitation in predicting that, barring man-made cataclysms, the next decade or two will see more advances in the war against mental disease than were registered in any previous century.

The signs are here. New warrants for optimism spring up in unexpected places. Among the most encouraging is the emergence of "practical politicians" as leaders in state mental health programs. For many decades, even before the organized mental health movement got under way, the declarations of so-called reformers that cut-rate custodial care for the mentally ill was not only inhumane but uneconomic were met by derision and cynicism on the part of the practical politicians. But today we witness multiplying signs that the practical politicians are heeding this truth, so tragically ignored heretofore.

They are sobered by such demonstrated facts as these:

Penny-pinching on mental hospital budgets, depriving large numbers of patients from an opportunity for speedy recovery and thereby dooming them to long-time institutional confinement, actually drains increasingly huge parts of the public budget—as much as one-fourth and even one-third of the total budget in some states.

* Keynote address presented at the Annual Meeting of the National Association for Mental Health, held October 23, 1954, in New York City.

Over 650,000 Americans are now resident in our public mental hospitals, and new patients are being admitted at the rate of 200,000 every year. (Think of it! Within the next five years one million Americans will become mental hospital patients for the first time, and more than half a million ex-patients will return to these hospitals as relapsed cases.)

The cost of maintaining the mentally ill now runs to one billion public tax dollars, and is mounting steadily as untreated and ill-treated cases accumulate in our institutions.

More and more practical politicians are reacting intelligently to such facts and figures, spurred on by the mental health movement. The Council of State Governments, representing the governors of all 48 states, has done extraordinary work in organizing governors' conferences on mental health, bringing the problem to the attention of politicians as a primary one for state executives, conducting mental health surveys and publishing outstanding reports, and urging concrete recommendations for adoption by the several states.

Incidentally, I've been disappointed, in my journalistic rounds, by the number of state mental health societies that have failed to utilize the findings and recommendations of the Council of State Governments, based on its own sound surveys of psychiatric hospitals, training, and research. The officially approved programs could provide very effective ammunition for state and local mental health campaigns. The recent Council-sponsored Governors' Conference on Mental Health has strongly urged that all state legislatures make considerable increases in mental hospital appropriations, most especially for expanded research and training programs. Mental health groups would do well to familiarize themselves with the 10-point program adopted by the Governors' Conference in 1954, for application in their own areas.

Under the stimulus of the Council, directed by Frank Bane, an increasing number of state governments are participating in regional conferences for cooperative mental health programs. Only a few months ago, ten midwestern state governments were represented at such a conference. The Southern Regional Education Board, representing 16 state governments, has already stimulated progressive programs for psychiatric treatment, research and training in the South.

The New York State Legislature of 1954 blazed a new trail—as significant as the pioneer State Care Act adopted 60 years ago by the same body—when it passed without a single dissenting vote the Community Mental Health Services Act. This statute provides for a 50 percent state financial share in such locally operated facilities as child guidance and community clinics, psychiatric wards in general hospitals, rehabilitation programs, and psychiatric consultative services to schools, health and welfare agencies, and the like. This development bids fair to break the serious financial bottleneck to the expansion of local services that can check effectively the increasing flow of men, women and children to our state hospitals, with attending heartbreak and wasteful expenditures. Also notable in 1954 was the overwhelming approval by both the legislature and general citizenry of New York of a \$350,000,000 bond issue for expanded and improved state mental health facilities.

The California State Mental Hygiene Department drafted a community mental health services program very similar to the one adopted in New York, which will be re-submitted to the next California Legislature, after being narrowly defeated in the 1955 session. Similar progress reports are received from state after state. Indiana, until recently one of the most benighted states in the mental health realm, is experiencing an impressive resurgence under the leadership of Dr. Margaret Morgan, the state mental health commissioner, actively supported by Governor Craig. The lowly bedlams of Kansas are being converted into first-class state mental institutions, thanks mainly to the untiring, dynamic stimulation of the Menningers of Topeka. Anyone who, like myself, went through the appalling bedlam that was the Topeka State Hospital a decade ago and has visited the same institution recently must feel as if he were witnessing a modern miracle. I recall a similar experience several years ago when I made a tour of Minnesota state hospitals with Governor Luther Youngdahl, now a federal judge, who had assumed the rôle of the leading crusader for modern psychiatric care and treatment in his state.

And so we witness, in state after state, the paradoxical spectacle in which hard-headed politicians, traditionally the

foes of mental health "reformers," take leadership in the very "reform" movement formerly despised as idealistic and impractical.

This heartening development in some states should not blind us, however, to the persisting evil of unwholesome political control in others. It is shameful to see, in our time, the continued use in many states of mental hospital systems as patronage mills for partisan politics, with wholesale ousters of personnel, from commissioners down to attendants, with every change in party control of the state machinery.

The mental health movement in America, in spite of chronic financial difficulties, has shown renewed vigor in recent years, especially since the great reorganization of the National Association for Mental Health. But it still suffers sadly from lack of clear direction and stable leadership. In my journeyings around the country I am heartened by the resurgence of organized mental health in some states, disappointed by the tendency in others to substitute glittering generalities about "positive mental health" while ignoring or understressing desperate needs of a concrete nature for which known correctives and solutions are at hand. I am particularly concerned with the tendency, in some mental health societies, to adopt a do-little attitude toward disgraceful and remediable conditions in most of our public mental hospitals. They expend their zeal rather in promoting ambiguous and often fleeting concepts about "mental health," along with confusing and mutually contradictory theories unsupported by solid scientific knowledge. There is a corollary tendency to concentrate on theoretical lectures for relatively small groups already sold on mental health while neglecting the task of developing mass support behind the application of tried techniques and procedures in the treatment of those who are already the victims of mental disease.

I do not mean to minimize the great importance of a search for a positive mental health program. My reference to "glittering generalities" applies to the trite homilies and slogans presented in the name of mental health, and also to the disposition to repeat glibly and endlessly the term "mental health" as though it had an intrinsic magic power like unto the mystic words on prayer-wheels. We have a growing body of knowledge about mental health techniques in certain areas of

life, and they are being put to use effectively in some places. Such programs should be pushed, but not at the price of neglecting the mentally sick.

I see, in too many states, a virtual abandonment of mental hospital patients by societies especially entrusted with the task of mobilizing public support for improved institutional conditions. Too many of us tend to forget that the mental health movement was founded by an ex-mental patient as a result of his own harrowing institutional experiences and observations. It remains a capital irony that the traditional neglect of hospitalized mental patients is too often supplemented by neglect on the part of groups supposedly dedicated to better care and treatment. Would that our mental hospital conditions were improved to such a degree that we could concentrate on the greater, though more distant, goals of educating the public in principles of mental health. Alas, this is not the case.

On this score, while proudly pointing to dramatic institutional advances in recent years, let us not forget that this progress is relative and that it stems from an appallingly low point of a decade ago, when many of our mental hospitals were not entitled to be called treatment places or even asylums in the real sense; when most of them showed the tragic evidence of accumulated decades of neglect, financial impoverishment, public apathy, legislative penury, and administrative despair; when, as an outstanding expert, Dr. Kenneth Appel, last year's president of the American Psychiatric Association, summed up the situation pithily:

"Conditions in our public mental hospitals are shocking, monstrous, and horrible. The majority of hospitals do not give treatment. They give custody—poor at that. Patients are herded like sheep. Automobiles get better attention than most mental patients today. The grass surrounding the state hospitals receives more care and consideration than the patients inside."

That terribly true indictment was uttered only a decade ago. When we record encouraging recent advances, we cannot ignore the sobering fact that after surveying most of our state mental hospitals the American Psychiatric Association's central inspection board could give its full approval to less than three percent of the surveyed institutions, and could give

conditional approval to less than 17 percent more. That leaves four out of every five state mental hospitals still on the unapproved list—a sorry record.

On the administrative side of the mental health picture, the two-year survey conducted by Raymond Fuller for the National Association for Mental Health (the findings of which were published in 1954) revealed the jumbled, anarchic state of governmental organization found in most states. As Mr. Fuller disclosed: "... while the task of state care and treatment has changed, the administrative means and mechanisms for performing it have not changed correspondingly. The tools provided for administration, the setups and systems of most states, remain archaic and inadequate, ill-fitted to the job to be done."

We still have far too many mental hospitals operated on a custodial rather than a therapeutic basis, where patients are deprived of the basic right to receive the benefits of modern psychiatric knowledge that might restore them to sanity. Three-fourths of our state mental hospitals still suffer from overcrowding—a condition that means far more than mere physical discomfort; it creates a chain of corollary conditions that effectively reduce the chances of recovery and even aggravate the disease in many patients. Nearly all our mental hospitals are still grossly understaffed. In too many hospital wards one still sees a shocking proportion of patients in strait-jackets, straps, and other mechanical restraints—barbaric vestiges that have been banished from our well conducted institutions. In too many wards one still sees evidence of grossly excessive sedation—at times adding drug addiction to the other burdens of mental patients. In too many hospitals increased per capita expenditures have barely kept pace with monetary inflation, giving a false sense of increase while failing to guarantee even minimum subsistence levels, let alone active therapy.

In too many states and communities persons who experience a mental breakdown at home are still removed by policemen untrained in humane and efficient handling of such patients. They are too often transported to lockups or jails in patrol wagons, rather than to hospitals in ambulances. Recently I received a letter from an ex-patient, now recovered, the wife of a college instructor, who lavished praise on the fine treat-

ment she had received in a public mental hospital but who has not gotten over the shock of the brutal handling she was subjected to by the police and jail keepers to whom she was entrusted before her commitment.

The quasi-criminal handling of mentally sick people pending commitment or other disposition persists in intolerable forms in too many communities boasting of civilized status. In this particular aspect, too, I find too many mental health societies so busily engaged in the dissemination of trite generalities that they overlook outrageous practices and procedures right at their own doorsteps.

In short, there is far too much tolerance of evils, abuses, and neglects in a society that boasts such great wealth and culture, too much acceptance of snake-pit levels in the handling of the mentally sick. I do not urge a reduction of activity on the preventive side of mental health; I do plead for greater attention to the plight of the more than half a million fellow-humans in our overcrowded, understaffed mental hospitals—the victims of mental disease who rate a priority on our attention.

In spite of the foregoing catalog of continuing defects, I cling more firmly than ever to an optimistic view of the immediate and ultimate future of the mental health movement. Compared to the tempo of evolution in former times, the developments of the past decade or two have been stupendous. Besides the enlistment of many powerful practical politicians in our ranks, we can regard with much satisfaction the inroads made against centuries-old myths about mental disease—such as the misconceptions that mental disease is a disgrace or a sin, that it is almost always hereditary, that it is never curable, and that it is typically manifested by violently dangerous behavior.

The American Psychiatric Association, during the last decade, has responded to the calls on professional responsibility by inaugurating many programs aimed at improving psychiatric standards through its mental hospital inspection and rating service, its annual mental hospital institutes, its special surveys, and its public education programs.

The American Medical Association, long neglectful of the general physicians' responsibilities in the mental health field, has established recently a committee on mental health, under

the able leadership of Dr. Leo Bartemeier, that promises to make significant contributions to greater medical and lay understanding of the mental disease problem.

The small but effective National Mental Health Committee, centered in the nation's capital, has done an impressive job in stimulating Congress and state legislatures to expand governmental support of psychiatric research and training.

The establishment of the National Institute of Mental Health within the U. S. Public Health Service in 1946 marked a milestone in the development of research and training resources, so desperately needed today. The transformation during the past decade of the Veterans Administration psychiatric facilities from the scorned "backwaters of American medicine" to first-rate therapeutic centers is little less than a miracle.

On the international scene, the slow but steady development of the World Federation for Mental Health since its founding six years ago as a clearing-house for information and activities is bringing dividends to the United States, along with other countries. Similarly with the mental health section of the World Health Organization, established about the same time.

In a thousand medical laboratories, psychiatric clinics, and hospitals, research into the causes, treatments, and possible methods of prevention of mental disease is piling up a steady accumulation of psychiatric knowledge that is bound to produce great, perhaps undreamed-of, discoveries in the not distant future. It is already heartening to be told by conservative psychiatrists that schizophrenia, not long ago widely considered a hopeless psychosis, can be treated successfully with modern therapies in from 40 to 60 percent of the cases. It is likewise heartening to be told that the recovery rate in involutional melancholia, another major psychosis, has been doubled in the last 20 years.

Help has come from non-psychiatric sources in the prevention and treatment of such psychiatric ailments as general paresis—syphilis of the central nervous system—which once accounted for more than one-tenth of the total mental hospital population and is now virtually disappearing, thanks to the discovery and application of penicillin. The same is true of the discovery of a simple vitamin treatment for pellagra,

which once contributed heavily to the patient load in a number of southern mental hospitals.

An increasing number of research centers are contributing valuable clues to the understanding and treatment of child behavior problems and of the mental disabilities of old age. The latter is of prime importance, since the so-called senile psychoses account today for the greatest proportion of mental hospital admissions.

In one psychiatric area after another, bright beams of optimism dispel the long shadows of despair. The acceleration of the war against mental illness offers people of good will everywhere one of the most vital medical and social challenges of our time. We in the mental health movement can enlist larger armies of recruits into this war and wage it more effectively if we:

Bring into sharper focus our immediate and long-term goals.

Substitute specific programs for vague generalities, with fewer allusions to the pie-in-the-sky type of "mental health" and more concentration on the fight against specific mental diseases.

Campaign vigorously for the elimination of correctible evils and abuses in the treatment of the mentally ill.

Spell out for ourselves and for potential allies the meanings of such psychoses as schizophrenia, manic-depressive psychosis, the so-called senile psychoses, along with the psychoneuroses and the psychiatric components in delinquency, narcotic addiction, alcoholism, and the like, so that people—ourselves included—will understand what we are driving at, and against.

Develop in our several states and localities concrete year-to-year as well as long-range programs based on known needs and realistic possibilities.

Seek actively to eliminate or reduce the many quasi-criminal procedures in the commitment of the mentally sick.

Help build up, on the basis of already-available knowledge, buttresses against relapses and rehospitalization of ex-patients returned to the community.

Seek out and put into practice the most effective distribution of our sparse professional psychiatric personnel.

Improve and expand volunteer service programs in psychi-



atric facilities that afford a double purpose of helping the mentally sick and widening public understanding of the problem.

Encourage sound research and training programs to explore the remaining areas of mystery in mental disease and to utilize more fully effective knowledge and techniques already available.

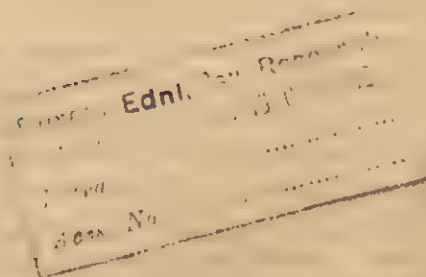
These are some of the measures we can push effectively in the movement. Not the least important, in my book, is the cultivation of a spirit of impatience and intolerance toward unnecessary and preventable human suffering; to remedy, as our prime short-term goal, the persisting evils and abuses in the care and treatment of the mentally sick. We have as our goals and our guides the inspiring demonstrations of remediable action in places where there were enough people who cared, people who flavored their indignation at injustices with know-how on the application of potent remedies. This immediate and urgent goal is not at odds with the long-time push toward positive mental health; it is a prerequisite for the latter.

"The promotion of positive mental health" has a progressive and reassuring ring; the idea has captured the imagination of many good-willed people, professional and lay. Certainly in the mental health movement we must push toward that ideal as far as our present knowledge and awareness of potentials permit us. But let us abjure vague and impotent generalities that only confuse the public and disorient our own purposes, and let us pay more heed to the overwhelming problem that faces us here, today, now—the menace of mental disease and its tragic toll among our child and adult population.

Let us frankly face the fact that while recent research has added considerably to our fund of knowledge about attainment of mental health, that knowledge remains incomplete, with large gaps and areas of contradiction. Yes, let us educate the public about what is fairly certain, but let us exercise more caution in promoting skimpy theories about the ingredients that go into the "good life." Let us try to pin-point our definitions about mental health so that they have maximum specificity, with meanings differentiated from other noble goals of human life.

It is my studied opinion that a major weakness of our movement lies in our over-emphasizing indefinite goals and ideals while failing to inform the public sufficiently about specific mental diseases that afflict so large a proportion of our population. I believe we will serve our ultimate purposes of promoting mental health more effectively if we come to closer grips with the current problems of improving the lot of the mentally sick.

The challenge remains great; the potential for meeting the challenge has grown ever so much brighter in recent years. There are millions of good citizens waiting to be recruited into the mental health movement. Let us gather them in, and move forward to our goals.



IDENTIFYING JUVENILE DELIN- QUENTS AND NEUROTICS

ELEANOR T. GLUECK *

Introduction

SINCE the publication of *Unraveling Juvenile Delinquency*¹ there has been much speculation concerning the capacity of the Social Prediction Table based on five factors in the intra-family relationships of the juvenile offenders and their matched non-delinquents (supervision of boy by mother, discipline by father, affection of mother for boy, affection of father for boy, cohesiveness of family) to distinguish at the age of six (i.e., roughly at the point of school entrance) those boys who, even though not yet necessarily showing indisputable signs of delinquency, are likely to become delinquents unless appropriate therapeutic intervention occurs. There has been concern in some quarters that data initially gathered about children between the ages of seven and 17 years may not necessarily reflect conditions that existed when they were six; and there have been questions concerning the "typicality" of the sample of cases studied in *Unraveling Juvenile Delinquency*, leading quite naturally to an uncertainty as to whether we have really developed "predictive" instruments or merely a syndromization of factors that markedly distinguish the 500 juvenile delinquents studied in *Unraveling Juvenile Delinquency* from their matched non-delinquents.²

* Co-author with Sheldon Glueck of *500 Criminal Careers*, New York, Alfred A. Knopf, 1930; *One Thousand Juvenile Delinquents*, Cambridge, Harvard University Press, 1934; *Five Hundred Delinquent Women*, New York, Alfred A. Knopf, 1934; *Preventing Crime* (editors), New York, McGraw-Hill Book Co., 1936; *Later Criminal Careers*, New York, Commonwealth Fund, 1937; *Juvenile Delinquents Grown Up*, New York, Commonwealth Fund, 1940; *Criminal Careers in Retrospect*, New York, Commonwealth Fund, 1943; *After-Conduct of Discharged Offenders*, New York and London, Macmillan Co., 1945; *Unraveling Juvenile Delinquency*, New York, Commonwealth Fund, 1950; *Delinquents in the Making*, New York, Harper and Brothers, 1952; *Physique and Delinquency* (to be published early in 1956), New York, Harper and Brothers.

¹ New York, Commonwealth Fund, 1950. Chap. XX, pp. 257-270.

² Burgess, Ernest W., book review in "Symposium on the Gluecks' Latest Research," *Federal Probation*, Vol. XV, 1951, pp. 2-3; Monachesi, Elio D., book review in "Symposium on the Gluecks' Latest Research," *Federal Probation*, Vol. XV, 1951, pp. 6-7; Polier, Justine W., book review in "Symposium on *Unraveling Juvenile Delinquency*," *Harvard Law Review*, Vol. 64, 1951, pp. 1036-1038; Reiss, Albert J., Jr., "Unraveling Juvenile Delinquency, II. An Appraisal of the Research Methods," *American Journal of Sociology*, Vol. LVII, 1951, pp.

It seemed to Professor Glueck and to me that there is only one meaningful answer to such speculation and that is, in the words of the eminent mathematical statistician, Edwin Bidwell Wilson, who has followed our attempts to construct "prediction" tables since the preparation of the first one (published in *500 Criminal Careers*) through 48 such tables:³

A tool for distinguishing confirmed delinquents from non-delinquents may or may not be serviceable in distinguishing within a group of non-delinquents those who are potential delinquents from those who are not.

One may argue about the probable serviceability of the tables for this suggested use. If one holds that the personality of an individual in respect to liability to delinquency is largely determined genetically or at any rate almost wholly determined genetically and environmentally prior to entrance to school, and that the syndrome of delinquency attributes can be observed as determinately in the earlier pre-delinquent age as later when delinquency has become confirmed, then one might also hold that the prediction tables would work pretty well—and one might fear that the preventive treatment might not easily be successful. If, however, one holds that personality or behavior is extremely labile and that delinquency arises not from genetic constitution nor even from pre-school conditioning but from associations and conditions surrounding the individual during his school years, then one might hold that the prediction tables would work badly, but he could entertain the hope for good success with preventive treatment if only he knew to whom to apply it.

A priori argument will not get far, howsoever it be extended. What one needs is trial and observation. . . . That the Gluecks realize all these difficulties is manifest throughout their writings; but they have not been deterred thereby from setting up prediction tables. And in respect to a table in an earlier book, namely, one which predicted behavior of civilian delinquents in the armed forces, they had a noteworthy success *a posteriori* in showing that of 200 military offenders who had been civilian offenders about 85 percent would have been so predicted to be.⁴ The proof of this pudding came in the eating.⁵

115-120; Rubin, Sol, "Unraveling Juvenile Delinquency, I. Illusions in a Research Project Using Matched Pairs," *American Journal of Sociology*, Vol. LVII, 1951, pp. 107-114; Shaplin, J. T., and Tiedeman, D. V., "Comment on the Juvenile Delinquency Prediction Tables in the Gluecks' *Unraveling Juvenile Delinquency*," *American Sociological Review*, Vol. 16, 1951, pp. 544-548; Tappan, Paul W., book review in "A Symposium on *Unraveling Juvenile Delinquency*," *Harvard Law Review*, Vol. 64, 1951, pp. 1027-1029.

³ A paper prepared by Eleanor T. Glueck in connection with the International Congress on Criminology, London, September 1955, entitled "Status of Glueck Prediction Studies," contains a history of this development and lists all these tables.

⁴ Schneider, A. J. N., LaGrone, Jr., C. W., Glueck, E. T., and Glueck, S., "Prediction of Behavior of Civilian Delinquents in the Armed Forces," *Mental Hygiene*, Vol. XXVIII, No. 3, July, 1944.

⁵ Wilson, Edwin Bidwell, in "A Symposium on *Unraveling Juvenile Delinquency*," *Harvard Law Review*, Vol. 64, 1951, p. 1041.

"Proof of the Pudding"

Since the publication of *Unraveling Juvenile Delinquency*, we have sought and encouraged opportunities first to test the Social Prediction Table by retrospective application to groups of delinquents (and in one instance it was possible to include non-delinquents), and then to subject it to the far more severe test of application in a first grade public school population.

Several validations applying this table retrospectively to boys already delinquent have been made to date and others are in process. While the findings cannot be regarded as absolutely definitive, they do afford persuasive evidence that the table is soundly based and markedly discriminative of delinquents versus non-delinquents. A review of the application of the Social Prediction Table to various samples of cases is derived from a paper prepared by the author for the International Congress of Criminology in London in September 1955.

The first validation study—made by Bertram J. Black and Selma J. Glick of the Jewish Board of Guardians in New York City—appeared in the spring of 1952. It is reported in a monograph entitled "Predicted vs. Actual Outcome for Delinquent Boys" (New York, Jewish Board of Guardians, 1952). The table was applied to a group of 100 Jewish boys confined in the Hawthorne-Cedar Knolls School in New York state, with a view to determining the extent to which it would have been possible years earlier to have accurately identified them as potentially serious delinquents. Black and Glick ascertained that 91 percent of the group would have been thus identified. It might be stated parenthetically that under the auspices of the Jewish Board of Guardians there has recently been completed a similar inquiry (as yet unpublished) concerning 150 Jewish unmarried mothers, with the finding that the table would have identified 81 percent as potential delinquents if applied several years before they were committed to the Hawthorne-Cedar Knolls School.

It is of especial significance that although the Social Prediction Table was compiled on the basis of underprivileged Boston boys largely of English, Italian, and Irish descent

and of Protestant and Catholic religions, it was found to operate so satisfactorily on a sample of New York Jewish boys; and that although it is based on boys, it yields such good results when applied to girls.

Another study, by Richard E. Thompson, entitled "A Validation of the Glueck Social Prediction Scale for Proneness to Delinquency" (published in the November-December, 1952, issue of the *Journal of Criminal Law*) establishes the Social Prediction Table as a valid instrumentality for distinguishing from among children already showing behavioral difficulties those who are true delinquents and those whose maladapted behavior is probably temporary. It shows that among a representative group of 100 boys, included originally in a research in Massachusetts known as the Cambridge-Somerville Youth Study,⁶ it would have been possible (as in the study by the Jewish Board of Guardians) to identify accurately 91 percent of all the boys as either potential delinquents or as true non-delinquents. The discriminative potential of the table was found to be considerably greater than that of three clinicians (psychiatrist, psychologist, and criminologist) who had been initially charged with selecting the boys for the Cambridge-Somerville Youth Study. Thompson reports that in the light of the actual behavior of the boys subsequent to their selection for the study, the clinicians (as determined by the staff of the study) had correctly identified 65 percent as true pre-delinquents or true non-delinquents, in comparison with 91 percent correctly identified by the Social Prediction Table.⁷

In this inquiry, as in that made by the Jewish Board of Guardians, the table reveals a capacity for usefulness on boys of status and background different from that of the boys on whom it was originally constructed, for its power was maintained among the boys in the Cambridge-Somerville Study who were younger than the boys in *Unraveling Juvenile Delinquency*; on those who were of different ethnic origin; on those who were of higher intelligence; on those of better economic status; and on those who grew up in neighborhoods that were

⁶ Powers, Edwin, and Witmer, Helen, *An Experiment in the Prevention of Delinquency*, New York, Columbia University Press, 1951.

⁷ See p. 464 *et seq.* of Thompson's article.

not as disadvantaged as those in which the boys in *Unraveling Juvenile Delinquency* were reared.⁸

More recently (summer 1954), Thompson, in an as yet unpublished study, applied the Social Prediction Table to 50 boys appearing before the Boston Juvenile Court in 1950 who averaged 13.1 years of age (as compared with an average age of 14.6 years of the boys in *Unraveling Juvenile Delinquency*). In retrospect, he found that had the table been applied when these boys were six years old it would have been possible to determine that 92 percent would, barring therapeutic intervention, become delinquents. These boys also differed in some ways from the original sample of cases on which the table had been constructed. Not only were they younger, but half of them had no prior court appearances (all the boys in *Unraveling Juvenile Delinquency* had been in court before). The religious distribution of these boys was also different, a higher proportion being Protestants than in the group studied in *Unraveling Juvenile Delinquency*. They were less retarded in school. In a higher proportion of cases they were the sons of two native-born parents; and, in a far higher proportion, one or both parents had attended high school.

Here again is evidence of the capacity of the table based on five social factors to discriminate between delinquents and non-delinquents on samples of different composition from the original.

Another opportunity to test the validity of the Social Prediction Table came in 1954 when the Douglas A. Thom Clinic for Children in Boston (a psychoanalytically oriented clinic) applied the table to 54 boys ranging in age from six to 12 years who had been treated for aggressive, destructive, antisocial behavior. The scorings made by the clinic psychologist indicated that 83.3 percent of these boys would have been clearly identified by the table at the age of six as potential delinquents. There is some question whether the boys not correctly identified were really pre-delinquents. (This can only be determined by intensive follow-up studies.) However, the evidence of the value of the table was sufficiently

⁸ *Ibid.*, pp. 467-469.

convincing to the clinicians themselves to encourage them in applying it to all their current cases (109 in number); and they are now at work on determining "what nuclear aspects of family interrelationships are reflected in the seemingly gross items regarding family life which make up the Social Prediction Table. We hope to contribute some dynamic formulations regarding this question."⁹

Still another check on the Social Prediction Table was published in April 1955.¹⁰ This is a study made by the New Jersey Department of Institutions and Agencies in which the table was applied to 51 delinquent boys who were on parole.

TWO-CLASS PREDICTION TABLE FROM FIVE FACTORS IN SOCIAL
BACKGROUND OF DELINQUENT BOYS¹¹

Weighted Failure Score Class	Unraveling Juvenile Delinquency	New Jersey Study
	%	%
Under 250 (little likelihood of delinquency)	14.2	19.6
250 and over (great likelihood of delinquency)	85.8	80.4
Total	100.0	100.0

The close resemblance in the distribution of both groups of cases is striking:

It will be observed that the closeness of the findings on the basis of the New Jersey data with the original findings in the study of *Unraveling Juvenile Delinquency* is rather noteworthy, since the New Jersey boys were selected at random, and no attempt was made to match the individual characteristics of the New Jersey delinquent boys with the delinquent boys included in the Harvard Law School Study.¹²

In addition to these retrospective checks of the Social Prediction Table, it has been applied since the fall of 1953 in two schools in New York City by the New York City Youth Board in an effort to identify potential delinquents at the point of school entrance (*i.e.*, in the first grade). These boys

⁹ Report to Prof. and Mrs. Sheldon Glueck prepared by Dr. Eveleen Rexford, director of the clinic, June 1954.

¹⁰ "Predicting Juvenile Delinquency," *Research Bulletin* No. 124, April 1955, published by the State Department of Institutions and Agencies, Trenton, N. J.

¹¹ *Ibid.*, p. 10.

¹² *Ibid.*, p. 9.

(as well as those screened as true non-delinquents) will be followed up in order to determine the extent to which the prediction of delinquency checks with actual developments in each case. A description of this experiment appears in the *Journal of Criminal Law and Criminology*.¹³

The Youth Board has reported that although 17 percent of those rated by the Social Prediction Table as potential *non-delinquents* manifested some behavioral difficulties during their first year in school, 72 percent of the boys who had been identified as potential delinquents manifested such difficulties. Although the evidence is not conclusive because it is concerned only with school misbehavior, it at least indicates the likelihood of the capacity of the table to discriminate between potential delinquents and true non-delinquents. A more intensive follow-up of these boys is under way, including inquiries about their behavior in home and community. Significantly enough, the clinicians who are at work in treating half the potential delinquents (the other half is being used as a control in order to make possible a determination of the effectiveness of treatment) have already found through their own psychiatric and psychological examination of these children that almost without exception mental pathology is present (severe neuroticism, pre-psychotic manifestations, character disorders, mental defects).¹⁴

After this paper was written, two additional validations of the Glueck Social Prediction Table were reported at the Third International Congress of Criminology in London in July 1955. The first, by Mrs. I. Lloyd Brandon, involves a psychiatric and social study of adult sex offenders at Sing Sing Prison, New York; the second, reported by Dr. Augusta Bonnard, involves a follow-up investigation of maladjusted children treated at the clinic of the London County Council. Details will be available when these two reports are published. I am in full agreement with Professor Glueck's conclusion that "all these successful experiments involve such a variety

¹³ Whelan, Ralph W., "An Experiment in Predicting Delinquency," *Journal of Criminal Law, Criminology and Police Science*, Vol. 45, No. 4, November-December 1954. Another aspect of this particular inquiry and one which provides a great challenge to psychiatrists is being designed to determine the extent to which appropriate psychotherapy will curb the development of delinquent careers.

¹⁴ Report from Mrs. Maude Craig, director of research, New York City Youth Board, 1954.

of investigators, of subjects to whom the table was applied, and of locales as to be hardly attributable to the 'long arm of coincidence.' "

*Opportunity to Construct Diagnostic Tables
Distinguishing Juvenile Delinquents from Neurotics*

Encouraged by the evidence thus far at hand, Professor Glueck and I determined to pursue our quest from data available in *Unraveling Juvenile Delinquency* to construct by the weighted score method¹⁵ three tables designed:

- (1) To distinguish neurotic delinquents from emotionally healthy delinquents.
- (2) To distinguish neurotic delinquents from neurotic non-delinquents.
- (3) To distinguish neurotic non-delinquents from emotionally healthy non-delinquents.

Because there were relatively few delinquent or non-delinquent boys in *Unraveling Juvenile Delinquency* who were either pre-psychotic or frankly psychotic, we excluded them from consideration entirely.¹⁶ For present purposes we also excluded those who were diagnosed as psychopathic or "asocial" because—although there was a considerable group of these among the delinquents (in a category combining the two)—there were relatively few among the non-delinquents.

¹⁵ As our weighted score method of constructing prediction tables is fully described in *Unraveling Juvenile Delinquency* (Chap. XX), as well as in our other works, there is no need to do more here than to point out that the five factors comprising the Social Prediction Table, for example, were initially selected from among those showing the widest range of difference in incidence between the 500 delinquents and their matched 500 non-delinquents. The percent of delinquents existing in each subcategory of a factor provides the basis for a total weighted score derived from summing the individual scores on the subcategories of all five factors in which a particular boy is placed. The table itself was derived from separately distributing all the delinquents and all the non-delinquents (for whom their status on all five factors was known) into "score classes." The incidence of the delinquents and of the non-delinquents within each "score class" expresses the likelihood that a distribution essentially like the one actually obtained in such an "experience table" will be found to exist in other similar samples of cases. Whether or not such a table has applicability to samples of different composition (in respect, for example, to ethnic makeup or economic status) had to await practical demonstration.

¹⁶ *Unraveling Juvenile Delinquency*, Table XVIII-43, Mental Pathology, p. 239.

It will be possible at a later time, however, to construct a table that will discriminate emotionally healthy youngsters not only from neurotics but also from those who are psychopathic or asocial.

It is to be hoped that similar devices for the "spotting" or "screening" or early "identification" or early "diagnosis" not only of delinquent but of emotionally disturbed non-delinquent children will be developed by others, notably by psychiatrists and psychologists, who have access to extensive and intensive case materials.

The reader is invited to consult *Unraveling Juvenile Delinquency* regarding the diagnostic procedures that led to a determination of neuroticism (including marked and mild neurotics and those with neurotic trends).¹⁷ Briefly, a comparison of diagnostic findings made by the Rorschach experts¹⁸ and the psychiatrist who examined the boys¹⁹ was made and differences in diagnostic classification were resolved in those few instances in which the diagnoses were conflicting.²⁰

Before proceeding to the construction of a table distinguishing neurotic from non-neurotic (emotionally healthy) delinquents, I should like to point out that we did not design the research which eventuated in *Unraveling Juvenile Delinquency* to encompass the development of the tables which form the subject of this paper. Had this been among our primary objectives, we would in the initial selection of delinquents and matched non-delinquents have deliberately included a greater number of neurotics as well as youngsters with other forms of mental pathology. The use of the data for the present purpose is purely a by-product of the larger work and must be accepted only as illustrative of the kind of instruments that mental hygienists might well develop to aid (by large-scale early identification) in the prophylaxis of emotional disturbance in the hope of preventing or intercepting the development of personality distortions.

For the present purpose analysis was made of 47 social fac-

¹⁷ See Chaps. XVIII and XIX.

¹⁸ Ernest G. Schachtel and the late Anna Hartoch Schachtel.

¹⁹ Dr. Bryant E. Moulton, who was for 12 years associated with the Judge Baker Guidance Center.

²⁰ *Unraveling Juvenile Delinquency*, p. 242, note 8.

tors, 42 traits of character structure (derived from the Rorschach test), and 18 traits of temperament (derived through psychiatric examination). Although in *Unraveling Juvenile Delinquency* we found when comparing delinquents as a group with their non-delinquent controls that they differed markedly in the factors reflecting what we have chosen to call the "under-the-roof culture," this did not prove to be significantly so in differentiating neurotic from non-neurotic (emotionally healthy) delinquents, neurotic delinquents from neurotic non-delinquents, and neurotic non-delinquents from emotionally healthy non-delinquents. It may well be that there were more subtle aspects in the early rearing of these children which would have reflected marked differences between the two groups, but in this inquiry, at least, they were not revealed.

Examination of the factors studied disclosed the most significant differences to be in traits of basic character structure (derived from the Rorschach Test), i.e., in the deposits in the personality of intrapsychic tension or conflict.²¹

*Distinguishing Neurotic from Non-Neurotic
(Emotionally Healthy) Juvenile Delinquents*

The first "screening" table that we have developed (which, of course, requires testing against other samples of cases) has to do with differentiating in a group of true delinquents (excluding for the present those who are pre-psychotic, psychotic, psychopathic, or asocial) between those who are neurotics and those who are emotionally healthy. Sufficient differences were not disclosed in the social background of neurotic and non-neurotic delinquents to make possible the construction of a diagnostic table utilizing social factors. But among the traits of basic character structure (derived from the Rorschach Test) there are 18 (out of a total of 42) from among

²¹ In order to develop suitable diagnostic instruments it was necessary to limit the initial selection of basic character traits (from among which five were to be chosen) to those not only significantly differentiating the neurotic delinquents from the neurotic non-delinquents, but at the same time also differentiating the neurotic non-delinquents from the non-delinquents who were non-neurotic (i.e., emotionally healthy). Otherwise, we would, in effect, be making a comparison of delinquents as a group with non-delinquents as a group (already accomplished in *Unraveling Juvenile Delinquency*—see Table XX-7, p. 264).

which we could make a choice of five as a basis for the "screening" or "diagnostic" table.²²

22 Trait *	Non-Neurotic Delinquents Percent	Neurotic Delinquents Percent	Difference In percent
Common Sense—XVII-6 (354 delinquents)	92.8	64.7	28.1
Social Assertiveness XVIII-2 (288 delinquents)	52.7	17.9	34.8
Defiance—XVIII-3 (326 delinquents)	35.5	56.0	-20.5
Enhanced Feeling of Insecurity and/or Anxiety XVIII-7 (338 delinquents)	6.4	52.9	-46.5
Feeling of Not Being Taken Care Of—XVIII-9 (235 delinquents)	19.6	46.3	-26.7
Feeling of Not Being Taken Seriously—XVIII-10 (274 delinquents)	28.9	87.2	-58.3
Feeling of Not Being Recognized—XVIII-11 (298 delinquents)	29.0	54.9	-25.9
Feeling of Helplessness XVIII-12 (317 delinquents)	30.7	75.5	-44.8
Fear of Failure and Defeat XVIII-13 (306 delinquents)	36.4	78.4	-42.0
Feeling of Resentment XVIII-14 (295 delinquents)	66.7	87.7	-21.0
Marked Suspiciousness—XVIII-23 (314 delinquents)	43.5	73.7	-30.2
Feeling of Isolation—XVIII-25 (262 delinquents)	31.8	72.1	-40.3
Defensive Attitude—XVIII-26 (321 delinquents)	43.5	82.2	-38.7
Conventionality—XVIII-29 (260 delinquents)	36.8	14.6	22.2
Feeling of Ability to Manage Own Life—XVIII-32 (242 delinquents)	87.9	44.9	37.0
Vivacity—XVIII-39 (145 delinquents)	50.0	31.1	18.9
Compulsory Trends—XVIII-40 (347 delinquents)	14.1	33.6	-19.5
Introversive Trends—XVIII-42 (260 delinquents)	23.7	42.5	-18.8

* The table number following each trait is from *Unraveling Delinquency*, to facilitate cross-reference. The figures in parentheses below each trait represent the number of known cases.

In selecting five traits from among the 18, we were guided by considerations largely related to (a) the number of known cases, and (b) the size of the differences between the incidence of a trait among the emotionally healthy delinquents, on the one hand, and the neurotic delinquents, on the other. The five traits chosen, with their sub-categories and their weighted scores are as follows:

<i>Traits</i> ²⁸	<i>Weighted Score</i>
Common Sense	
Present *	73.9
Absent	28.8
Enhanced Feeling of Insecurity and/or Anxiety	
Absent	81.7
Present	21.4
Feeling of Helplessness and Powerlessness	
Absent	85.6
Present	46.1
Fear of Failure and Defeat	
Absent	86.4
Present	50.0
Defensive Attitude	
Absent	86.4
Present	51.4

²⁸ *Common Sense*: "The faculty of thinking and acting in the ways of the community; it may be present even if some acts of the individual run counter to accepted mores; there may be, for instance, a conflict between common sense and a fantastic thirst for adventure." *Enhanced Feeling of Insecurity and/or Anxiety*: "While insecurity and anxiety play a considerable role not only in pathological cases but also in many normal persons, enhanced insecurity and/or anxiety designates a state in which these feelings play a decidedly stronger role in the personality, either quantitatively or qualitatively, than is usual in the average person. They may, however, remain largely unconscious." *Feeling of Helplessness and Powerlessness*: "Particularly frequent and important, and very often unconscious kind of insecurity feeling, in which the individual feels he cannot do or change or influence anything, especially with regard to the course of his own life." *Fear of Failure and Defeat*: "A frequent consequence of anxiety, especially in persons with an overcompetitive attitude. Fear of failure may concern every sphere of life, not only work or play, but all human relations. It may lead either to greater effort or to inhibitions, aloofness, and to recoiling from competition." *Defensive Attitude*: "Unwarranted defensiveness, either exaggerated in proportion to the attack, or the attack is entirely imagined. The means of defending oneself are varied: they consist sometimes of a 'shell-like' attitude of warding off every approach and erecting a wall around oneself; they sometimes take a more aggressive form, as, for instance, in persons who are very sensitive to any criticism and are provoked by it to defiant or obstinate or opinionated behavior; and so on." (All terms defined by Ernest and the late Anna Hartoch Schachtel for *Unraveling Juvenile Delinquency*.)

* In *Unraveling Juvenile Delinquency*, the Rorschach traits were divided into three categories: If a trait was present in large degree in the character structure or

The highest possible weighted score that any one boy can be assigned is 414, the lowest 197.7.

The resulting table provides for four score classes.

TABLE 1. EMOTIONALLY HEALTHY AND NEUROTIC JUVENILE DELINQUENTS IN EACH OF FOUR WEIGHTED SCORE CLASSES BASED ON FIVE CHARACTER TRAITS DERIVED FROM BORSCHACH TEST

Weighted Score Class	Percent of Emotionally Healthy Delinquents		Percent of Neurotic Delinquents		Total
	No.	%	No.	%	
Under 200	0	0.0	15	100.0	15
200-299	8	21.1	30	78.9	38
300-399	92	76.7	28	23.3	120
400 and over	69	100.0	0	0.0	69
TOTAL CASES	169		73		242

Coefficient of Correlation .872

Assuming its validation, the table indicates that if a boy scores under 299 on the five traits the likelihood that he is neurotic is very great. It would appear to be a certainty that he is if he scores under 200. If he scores 300 and over there is a strong likelihood that he is emotionally healthy; this becomes practically a certainty if he scores 400 or over.

Distinguishing Neurotic Delinquents from Neurotic Non-Delinquents

The second screening device made possible by our materials is designed to distinguish neurotics who are likely to act out their aggressive impulses from those who turn their aggressiveness against themselves. Such a differentiation ought to be of assistance to clinicians who are charged with the psychotherapy of neurotics.

dynamics, it was designated as *marked*; if the presence of a trait was only suggestive or indicated to a low degree, it was designated as *slight* or *suggestive*; if a trait did not play a relevant or significant role in the character structure, it was designated as *absent*. Ernest Schachtel has said of this categorization: "I suppose that one can find almost every trait at some time and to some degree in most persons; . . . but by the use of these classifications we want to indicate whether or not the traits in question play a considerable role in the structure of the personality." (p. 209)

Examination of the findings resulted in combining in four of five of the traits the category *marked* and *slight* or *suggestive*; and in one trait the category *slight* or *absent*.

Of the total of 42 traits, there were 12 which sufficiently differentiated the two groups to be utilizable in a screening table.²⁴

In the final selection of five traits, we were again guided essentially by considerations relating to (a) the number of known cases, and (b) the widest percentage differences between the incidence of a trait among the neurotic delinquents and the neurotic non-delinquents. These considerations re-

24 Traits *	Neurotic	Neurotic	Difference In percent
	Delinquents Percent	Non- Delinquents Percent	
Enhanced Feeling of Insecurity and/or Anxiety—XVIII-7 (104 dels., 148 non-dels.).....	52.9	72.3	--19.4
Feeling of Not Being Recognized or Appreciated—XVIII-11 (91 dels., 96 non-dels.).....	54.9	38.5	16.4
Suspiciousness—XVIII-23 (114 dels., 146 non-dels.).....	73.7	54.8	18.9
Destructiveness—XVIII-24 (85 dels., 134 non-dels.).....	47.1	22.4	24.7
Conventionality—XVIII-29 (89 dels., 117 non-dels.).....	14.6	38.5	--23.9
Manage Own Life—XVIII-32 (69 dels., 119 non-dels.).....	44.9	26.9	18.0
Masochistic—XVIII-34 (108 dels., 124 non-dels.).....	27.8	61.3	--33.5
Destructive-Sadistic—XVIII-36 (85 dels., 134 non-dels.).....	48.2	23.1	25.1
Self-Control—XVIII-38 (116 dels., 166 non-dels.).....	37.9	55.4	--17.5
Vivacity—XVIII-39 (61 dels., 94 non-dels.).....	31.1	6.4	24.7
Compulsory Trends—XVIII-40 (113 dels., 155 non-dels.).....	33.6	56.8	--23.2
Preponderance of Extroversive Trends—XVIII-41 (90 dels., 129 non-dels.).....	38.9	22.5	16.4

* The table number following each trait is a cross-reference to chapters and tables in *Unraveling Juvenile Delinquency* in which the particular trait is analyzed. The figures in parentheses are the number of known cases of delinquents and non-delinquents whose status is known in regard to the presence or absence of the trait.

sulted in utilizing the following five traits, which are presented with their subcategories and weighted scores:

<i>Traits</i> ²⁵	<i>Weighted Score</i>
Enhanced Feeling of Insecurity and/or Anxiety	
Absent	54.4
Present	84.0
Suspiciousness	
Present	51.2
Slight or absent	81.3
Masochistic Trends	
Absent	61.9
Present	28.3
Self-Control	
Absent	49.3
Present	32.4
Compulsory Trends	
Absent	52.8
Present	30.2

Summations of the highest and of the lowest possible total weighted score that can be achieved by an individual in order to establish his status on the five traits are 269.6 and 156.2 respectively. Within these limits, the neurotic delinquents and the neurotic non-delinquents were distributed within "score classes" in each of the two groups separately.

This resulted in Table 2 from which it is determined (assuming its validation on other samples of cases) that among a group of neurotics a boy scoring under 200 is not likely to act out his aggressive impulses; one scoring 250 and over very probably will do so.

²⁵ *Enhanced Feeling of Insecurity and/or Anxiety*: (See Note 23 for definition). *Suspiciousness*: "Indiscriminate or exaggerated suspicion toward others, not warranted by the objective situation. The person is usually not aware that he is unduly suspicious. He thinks rather that he is merely cautious or realistic, or that he is really being persecuted, and so on." *Masochistic Trends*: "A tendency to suffer and to be dependent." *Self-Control*: "The faculty of controlling the discharge and expression of affectivity (in no way identical with the faculty of the healthy and mature person of determining the direction and way of his life and what he wants to get out of his life within the given circumstances)." *Compulsory Trends*: Includes "both the classical neurotic compulsions as well as the less dramatic and less manifest cases of a rigidity that does not permit of flexible adaptation to changing situations, and usually originates from anxiety. It is an attempt to overcome anxiety and to defend oneself against it. The anxiety may be conscious or, more often, unconscious."

TABLE 2. NEUROTIC DELINQUENTS AND NEUROTIC NON-DELINQUENTS IN EACH OF THREE WEIGHTED SCORE CLASSES BASED ON FIVE TRAITS OF CHARACTER STRUCTURE DERIVED FROM RORSCHACH TEST

Weighted Score Class	Neurotic Delinquents		Neurotic Non-Delinquents		Total
	No.	%	No.	%	
Under 200	16	20.7	61	79.3	77
200-249	56	70.9	23	29.1	79
250 and over	12	92.3	1	7.7	13
TOTAL CASES	84		85		169

Coefficient of Correlation .613

*Distinguishing Neurotic Non-Delinquents from
Non-Neurotic (Emotionally Healthy) Non-Delinquents*

Although our primary focus of interest is in the development of instruments for the early detection of delinquents, the control group of non-delinquents in *Unraveling Juvenile Delinquency* makes it possible for us to step out of the area of distinguishing between those among delinquents or potential delinquents who are neurotic and non-neurotic to consider the screening of non-delinquents as neurotics or non-neurotics. Although we are hesitant to go beyond the limits of our special field of inquiry, we permit ourselves to do so because there is significance, as will be seen below, in the fact that three of the five traits that markedly distinguish neurotic delinquents from non-neurotic delinquents also distinguish neurotic non-delinquents from non-neurotic non-delinquents. As two of the traits are different, however, there would appear to be evidence that delinquency is an entity always different in some respect from other forms of emotional disturbance. Apart from this, those who are concerned with the early recognition and treatment of emotional illness may find this third table suggestive and worthy of testing against other samples of cases.

Unlike the other two tables, in which an insufficient number of social background factors was found to differentiate the two groups involved, there are six social factors that distinguish neurotics from emotionally healthy boys among the non-delinquents in *Unraveling Juvenile Delinquency*.

The factors are: working mother (40.2% among neurotics vs. 26.3% among the non-neurotics), inadequate supervision

by mother (40.8% vs. 28.7%), unsuitable (lax, erratic, over-strict) discipline by mother (44.3% vs. 28%), unfriendliness of parents to children's friends (66.9% vs. 57.7%), meager home recreational facilities (41.2% vs. 30.9%), lack of attachment of boy to father (40.1% vs. 32.4%). However, the differences are not as great as those found in the incidence of certain character traits.²⁶ (Even were the differences more marked

28		Neurotic	Non-Neurotic	
	Traits *	Non-Dels.	Non-Dels.	Difference
Common Sense—XVII-6				
(441 non-delinquents).....		66.9	94.9	—28.0
Methodical Approach to				
Problems—XVII-10				
(428 non-delinquents).....		25.3	44.0	—18.7
Social Assertiveness—XVIII-2				
(381 non-delinquents).....		3.7	31.7	—28.0
Enhanced Feeling of Insecurity				
and/or Anxiety—XVIII-7				
(414 non-delinquents).....		72.3	4.9	67.4
Feeling of Not Being Taken				
Care of—XVIII-9				
(295 non-delinquents).....		58.7	8.4	50.3
Marked Feeling of Not Being				
Taken Seriously—XVIII-10				
(335 non-delinquents).....		83.0	32.0	51.0
Feeling of Helplessness and				
Powerlessness—XVIII-12				
(370 non-delinquents).....		88.7	33.3	55.4
Fear of Failure and Defeat—XVIII-13				
(395 non-delinquents).....		89.1	47.7	41.4
Feeling of Resentment—XVIII-14				
(296 non-delinquents).....		81.7	33.2	48.5
Hostility—XVIII-22				
(333 non-delinquents).....		76.7	40.2	36.5
Marked Suspiciousness—XVIII-23				
(377 non-delinquents).....		54.8	8.7	46.1
Feeling of Isolation—XVIII-25				
(321 non-delinquents).....		70.5	17.2	53.3
Defensive Attitude—XVIII-26				
(389 non-delinquents).....		77.5	24.4	53.1
Feeling of Being Able to Manage				
Own Life—XVIII-32				
(303 non-delinquents).....		26.9	89.7	—62.8
Masochistic Trends—XVIII-34				
(358 non-delinquents).....		61.3	26.1	35.2

than they are, we would prefer to utilize traits of basic character structure in order to keep to a uniform method of screening large populations of children.)

Applying the same considerations as in the two prior tables to the selection of five traits on which to construct a screening table, we have utilized the following five traits presented here with their subcategories and weighted scores :

<i>Traits</i> ²⁷	<i>Weighted Score</i>
Enhanced Feeling of Insecurity and/or Anxiety	
Present	89.2
Absent	14.0
Fear of Failure and Defeat	
Present	54.9
Absent	12.0
Feeling of Resentment	
Present	58.9
Absent	13.8
Defensive Attitude	
Present	66.9
Absent	15.9
Compulsory Trends	
Present	68.2
Absent	23.3

The highest possible score in an individual case is found to be 338.1, the lowest 79.0.

Table 3 has been constructed from these five traits and (assuming its validation) is designed to distinguish neurotics from non-neurotics in a general school population (without reference, however, to pre-psychotic, frankly psychotic, or psychopathic or asocial children).

Self-Control—XVIII-38			
(424 non-delinquents).....	55.4	77.1	—21.7
Vivacity—XVIII-39			
(166 non-delinquents).....	6.4	38.9	—32.5
Compulsory Trends—XVIII-40			
(417 non-delinquents).....	56.8	15.6	41.2

* The table number following each trait is from *Unraveling Juvenile Delinquency* to facilitate cross-reference. The figures in parentheses are the number of cases in which the data were known.

²⁷ *Feeling of Resentment*: "The feeling of frustration, envy, or dissatisfaction, with particular emphasis not on the positive attempt or hope to better one's own situation, but on the negative wish that others should be denied the satisfaction or enjoyment that one feels is lacking or withheld from oneself." For definitions of the other traits, see notes 23 and 25.

TABLE 3. NEUROTIC AND NON-NEUROTIC (EMOTIONALLY HEALTHY) NON-DELINQUENTS IN EACH OF FOUR WEIGHTED SCORE CLASSES BASED ON FIVE CHARACTER TRAITS DERIVED FROM RORSCHACH TEST

Weighted Score Class	Neurotic Non-Delinquents		Non-Neurotic Non-Delinquents		Total
	No.	%	No.	%	
Under 200	13	10.8	112	89.2	125
200-249	10	41.7	15	58.3	25
250-299	20	76.9	9	23.1	29
300 and over	33	94.1	2	5.9	35
TOTAL CASES	76		138		214

Coefficient of Correlation .923

From this table it is determined (assuming its validation on other samples of cases) that if a boy scores under 200, there is little likelihood that he is a neurotic; if he scores 300 and over, it is very likely that he is a neurotic.

* * *

The value of such discriminative instruments will be determined only by experimental application. The problem of skillful administration and interpretation of Rorschach Test findings may limit the usefulness of such instruments. It may be, however, that simpler projective tests can be developed which would elicit the data needed.

Perhaps a group Rorschach Test (or other projective tests) could be devised which would focus on the particular traits of basic character structure that appear to be significant in differentiating between neurotic delinquents and neurotic non-delinquents, between neurotic delinquents and non-neurotic (emotionally healthy) delinquents, and between neurotic and emotionally healthy non-delinquents.

A beginning must be made in utilizing tables such as the three presented here in order to determine how well they apply in other samples. Some such syndromization of traits or "symptoms," if you will, makes possible the arrival at "diagnoses" by methods other than purely psychiatric, and by persons other than psychiatrists. From the trend of evidence in the checks that have thus far been made of the Social Prediction Table developed in *Unraveling Juvenile Delinquency*, we are encouraged to think that we have in these three new diagnostic instrumentalities additional means for early recognition of

neuroticism in delinquents and non-delinquents. We envisage the use of these three discriminatory tables as a supplement to the Social Prediction Table in order that following the "spotting" of potential delinquents a further step can be taken in distinguishing the emotionally healthy delinquents and non-delinquents from the neurotics, and also in sorting out from among neurotics those who are likely to act out their aggressive impulses and those who are not. If, in addition, we can develop a table designed to identify those who are psychopathic or asocial, the mass screening of children (through group projective tests) at the point of school entrance would be closer to realization, making possible a concerted attack on delinquency and emotional disturbance in their incipient stages.

CULTURAL ELEMENTS IN GROUP PSYCHOTHERAPY: SOME PROBLEMS FOR STUDY *

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THE relevance of a patient's socio-cultural group memberships to his performance in at least the opening meetings of psychotherapy groups has, to the best of my knowledge, received no systematic study. Nor is this paper going to provide us with the findings of an orderly inquiry into this problem. Rather, out of retrospective impressions, with the insights of hindsight, I shall describe what look like repeated patterns of patients' behavior — patterns which seem to be related to the patients' cultural affiliations as well as to the "cultures" of the therapy groups themselves. The patients' behavior was observed and recorded in a dozen out-patient clinic therapeutic groups.

Unfortunately, in the original study, reported in full elsewhere,¹ we had no curiosity or hypotheses about the patients' ethnic or social class backgrounds. We therefore failed to obtain from all patients, in any systematic way, the facts which seem now so essential.² What I present here are therefore hunches derived in retrospect from incomplete data — questions for further study.

The patterns are drawn from records on group psychotherapy sessions composed primarily of neurotics. I am not referring to our group work with hospitalized psychotics who, as I saw them, seemed more or less acultural. One might postulate that if their cultural beliefs and values and the content of the rôles they had been exposed to in childhood, adolescence, and their young adult years had seemed applicable and supportive to them in the extremely stressful situa-

* Presented at the first annual western regional meeting of the American Group Psychotherapy Association in Berkeley, Calif., June 1954.

¹ *Group Psychotherapy: Studies in Methodology of Research and Therapy*, by F. Powdermaker and J. D. Frank. Cambridge, Harvard University Press, 1953.

² Knowledge of our many patients' G I Bill student status served merely to conceal occupational and social class status. Such data cannot lead to any valid generalizations about the relationships between patients' social position and their differential reactions to group psychotherapy.

tions to which they adapted by becoming psychotic, they would never have become psychotic.

Unlike the acultural psychotics, the psychoneurotics in our clinical study were the prisoners of their cultural heritage. Either the don'ts of their social milieu had overwhelmingly failed for them to counterbalance the do's, or the do's had never been quite fulfillable — and the men were still working on them. Finding themselves for the first time in their young lives seated in a room with a psychiatrist as a designated "leader" and with from five to a dozen other patients present, most of the men were still working on overwhelming don'ts and unfulfilled do's. The fact that the don'ts and the do's were in many ways irreconcilable and yet binding for those patients must, we may hypothesize, have affected the nature of the transition they had to make to the group psychotherapeutic cultures.

And how may we describe them — the cultures of our therapeutic groups? Their values included and induced the expression of true affect, especially anger and other elsewhere allegedly unacceptable feelings. Their mores, sometimes explicitly stated by the psychiatrist at the early sessions of a group, encouraged the revelation and analysis of personal weaknesses and inadequacies in performance in family, work, and school situations outside the therapeutic group. (Later, in-group phenomena would be studied.) Social skills, built into the initial reciprocal rôles of patient and therapist, varied principally with the style of leadership offered in early meetings by the psychiatrist. Such leadership style, a major differential element in the therapy group cultures, may be schematized and dichotomized as follows:

The psychiatrist initially induced either primarily patient-to-patient relationships or patient-to-therapist relationships. In fostering patient-to-patient relationships, the psychiatrist may have sat by passively, an interested observer, but somewhat peripheral to interaction among the patients, for either explicitly planned reasons or less manifestly rational motives of his own. He may actively have deflected the first few patients' questions or statements directed his way, throwing them back to the group or to another patient. His actual behavior and attitudes may have varied considerably from those of another therapist. Still, to the observer, what ap-

peared in one *type* of group culture, during early meetings, was the development of much interaction among the patients and the organization of a group structure which placed in the topmost position one of the patients.

In the other type of group culture, in which the psychiatrist's style induced patient-therapist relationships, the interaction pattern revealed quantitatively less patient-to-patient give-and-take and a resulting group structure which unquestioningly set the therapist in the highest status and ranked the patients somewhat competitively in slots further from or closer to the physician. The data we had on patients' improvement enabled us to say that neither of these approaches induced more patients to stay on in or to drop out of treatment during the early meetings. From both types of group, under both types of therapist style, patients dropped out.³ But who were these patients who dropped out of either type of situation? Here, I believe, knowledge of certain cultural facts about the patients is germane.

Why? What are the theory and relevant studies? Dr. Paul Barrabee of Harvard recently reported on an investigation, done at Boston Psychopathic Hospital, of family patterns among Italian, Irish, Jewish, and Yankee patients.⁴ Since some of his findings agree with parts of a study I did some years ago in Chicago,⁵ I should like to make somewhat free use of his formulations, combining them with mine, and then relate some of these factors to the cultures of our therapy groups.

Barrabee describes the Irish and Italian families as having what he calls "respect (or position) solidarity," in which the individual is subordinate to the group. In this type of family, there may be anxiety over one's place or position in the family; there are "status controls" but no rewards. One is expected to respect the dominant parent figure. By comparison, Barrabee finds in the Yankee and Jewish families what he calls "love solidarity," in which the individual is valued

³ See Chap. IV, "Patients Who Left Groups," *ibid.*, pp. 77-94.

⁴ "How Cultural Factors Affect Family Life," by Paul Barrabee. *Social Welfare Forum*, 1954. New York, Columbia University Press, 1954, pp. 17-30.

⁵ "Some Social Class Differences in the Family Systems and Group Relations of Pre- and Early Adolescents," by H. S. Maas. *Child Development*, Vol. 22, June 1951, pp. 145-152. (Reprinted in *The Adolescent: A Book of Readings*, by J. M. Seidman (ed.). New York, Dryden Press, 1953, pp. 456-464.)

qua individual. In this type of family there is anxiety over being loved, a condition often depending upon adequate rôle performance. There may be a sense of indebtedness to the mother who expects obedience as her moral right for the ostensible good of the child — not the group.

In a comparable study, we observed and interviewed early adolescent boys and girls in neighborhood center youth groups. Our data on slum area children, many of whom were Mexican, Negro, and Italian, were compared with comparable data on largely Protestant, middle-class Caucasians. In the latter group we found a much more "open, ostensibly equalitarian and flexible relationship" between the youths and their parents, in the lower-class and ethnic groups "a psychologically closed, hierarchical, and quite rigid parental relationship with children."⁶ Psychological distance between parent and early adolescent child seemed much greater in the lower-class than in the middle-class groups; working mothers and otherwise busy parents were often in many ways remote and when present gave orders and peremptory physical punishment to their adolescent children. The children seemed to respond in early adolescence with fear of parent figures. In the neighborhood centers they seemed markedly ambivalent about the adult group leaders; they tested them, challenged them, or responded with passive compliance to requests.

The middle-class or "core culture" children frequently shared decisions with parents, at times openly opposed or manipulated them to the child's own ends, and clearly showed no fear of adults, but rather a capacity to speak as equals with them, to accept them, and to get along in their club meetings quite competently without them. Unlike the slum area adolescents, these boys and girls had no trouble with adult group leaders; their difficulties were more or less with one another, their peers.

The slum area early teen-agers had their street gangs in which physical power — expressed frequently as physical violence — was accepted, even highly valued, and led for some of them to what they seemed unable to attain in their respect or position solidarity families — a high status. For others, submissive subordination was an acceptable, comfortable,

⁶ *Ibid.*, p. 147.

familiar position. At home, father was not replaceable; only in his absence, in the street gang, could father-leader status be fought for and achieved.

Among the middle-class youth, parental approval, if not love, had long been awarded them as children when such rôles as "good boy" or "good girl," "good school pupil," and "good child in the neighbor's eyes" were adequately fulfilled. Competitiveness among age-mates and siblings arose for the love and approval of parent-adults — whether father, mother, teacher, or neighbor. The adult was the source of rewards, not a symbol of fear. For the healthy early adolescent in the middle classes who had internalized parental and other adults' sanctions, the adult had served his purposes, and could now be questioned, disposed of, or supplemented if need be. On the other hand, the authoritative, often punitive, overtly aggressive, to-be-respected-and-never-questioned parent, store owner, and policeman, known to children and adolescents in the roving street gangs in Chicago, remained a distant and fearful symbol of adulthood — at least for the slum area boys and girls we studied.

Counterparts of some of the latter and some of the former as young adults entered our therapy groups. Some of these groups, remember, quickly became patient-patient or therapist-patient cultures. What happened? Let me describe seven of the patients, their behavior in the early meetings of two groups, and their backgrounds. I shall have to limit myself to very brief comments about even these few.

Fio⁷ entered the group at about the fourth meeting. With characteristic force, after he got the lay of the land, he burst in with direct counsel to another patient who was expressing concern about sex play with his girl friend and masturbation. Fio seemed openly aggressive, called a spade a spade, and evoked an intervention from Dr. A in which the latter sought to protect the self-revealing patient from Fio's direct approach. Dr. A in this group characteristically fostered therapist-patient relationships. Although he encouraged the expression of hostile feelings, their overt and facile expression by patients like Fio seemed to evoke his concern for those

⁷ All patient names used in this paper are pseudonyms. Other data are somewhat disguised to conceal patients' identities.

other patients whose tolerance for such hostility seemed to him to be low, and he regularly suppressed patients like Fio in his group.

Fio had run away in mid-adolescence from his Italian-ethnic family living in Baltimore slums. The family, as described by Fio in an interview, would be characterized by Barrabee as a respect-solidarity family. Father's word was law. In opposition and hatred, Fio could only flee. Following trouble with officers in the military, Fio faced a series of problems with civilian bosses. Each job was abandoned. In a therapy group in which the parent-figure intervened, Fio could not remain. Fio never returned.

From the same group, O'Hara, with a similar approach to other patients and an obvious dread of Dr. A, came every other session for four of the early sessions, then never returned. O'Hara had not completely lost contact with his respect-solidarity family. In an interview he described his sporadic, hopeful visits to his parents' home, bringing a dozen eggs as a gift, and then the periods of withdrawal and not allowing himself to visit. O'Hara worked as a pole climber for a utilities company. The don'ts of "don't show disrespect to the father" and "don't live for yourself but for the group" — for example, "turn in to the family faithfully all your salary" — were too much for him. Ostensibly he quit the therapy group because Gold, another patient, talked of his former officer status in the Army, and, as O'Hara told me, "I swore I'd kill every officer I met, once I was out." Dr. A, incidentally, was known to have been a major in the Medical Corps.

In this group of Dr. A, Gold stayed on, ignoring the other patients and discussing in the rôle of good patient for Dr. A all his fantasies of terror as well as his personal inadequacies on the professional job he was engaged in. Dr. A responded with interest and attention to Gold's appropriate performance; Gold was the bellwether, the model patient in this milieu. Gold had learned from his mother the do's of a good son and a good student; that he had not gotten all the approval and love from his father to which he believed himself entitled for such good performance — that his sister won his father's love instead — may have been related to Gold's repeated, lifelong efforts to excel in situations in which approval from a superior

might be gained. For the milieu of Dr. A's group Gold had been well acculturated, and the transition was, to this type of therapy group, an easy one for him. So much for the first three patients and Dr. A's group.

In Dr. B's group, Prescott, from a long line of Virginians, and Reisman, a young Jewish veteran, lasted only a few sessions. In terms of familial values, relations with an overly approving mother, suppression of unpleasant affect and occupational aspirations, Prescott and Reisman were in many ways comparable to each other and to Gold. Dr. B, however, was quite different in style from Dr. A, and the patterns in these two groups were quite different. Dr. B sat back, almost actively withdrew, relating patient to patient when one of them did address him. He explained that at first he did not want to become buddy-buddy with the patients, so he held himself aloof. In turn, Prescott and, then when he had left after three meetings, Reisman, became the pseudo-therapists or leaders of this group. They solicited discussions of patients' problems and attempted to analyze their complaints, but there were no rewards from the parent-figure for even this performance, and their interests in the other patients seemed completely spurious and manipulative. When Prescott complained that Dr. B did not give "enough Freudian interpretations," he was rebuked; Prescott quit. When Reisman quit, after having played the pseudo-therapist rôle for a few sessions, he remarked not too cryptically, "I didn't have the privilege of being the only one there, and there was no particular path to go on." He had proved he was "the top man saying the most important things." But Dr. B—who after an early meeting said, "I was afraid to say something to any one man; it might seem too significant"—was giving no approval or other rewards for such good performance. This was an unfamiliar parent rôle for Reisman and Prescott. For someone like Reisman, highly competitive with peers and siblings, the do's as determined by the parent were not clear enough—and truly there was "no particular path to go on."

For Bocci, a third patient in this group, the ninth and youngest child in an Italian-ethnic family, whose father had for years dashed cold water in his face to wake him for work in the mornings, the culture of Dr. B's group was perfect. Bocci was the chief and successful contender for the leader's

position—aggressive, energetic, an old hand in an unsupervised boys' group. To Olem, also from an economically depressed, hierarchical, respect-solidarity family—to Olem, fearful of Bocci but even more fearful of Dr. B, symbolically, the patient-patient relationship structure was essential. Had Dr. B been active, inducing doctor-patient relationships, Olem would have fled the group in fear. Relationships with peers—fellow-patients in a street gang—and support from them, even in a low-man status, was essential before Olem could approach the fearful omnipotence of the parent-leader-adult-psychiatrist. Tolerance for aggression from peers, in a group unsupervised by adults in the back alleys of the city, had been well learned. The do's of this group's culture were not overwhelming for Olem or Bocci; the paramount don't was the familiar "don't express true feelings to the father." One could survive well among siblings and age-mates, fighting to a top rung in the hierarchy or finding and hiding comfortably in a subordinate position. In the group cultures where the therapist sat back, the child of the gang and the slum was initially at home. Uncontrolled aggression and counter-aggression or submission among peers were not his problem. Intimate feeling relations with the adult were the uncompensated for don't.

In such a group culture, however, for Prescott and Reisman (and for Gold), whom some adults had rewarded and for whom most adults were non-threatening, survival was impossible. Other patients were, as Reisman said, just "sticks." For Gold they were the somewhat frightening enemy. They were not supports, as they were for Olem (and O'Hara); they were not essential for one's own superordinate position, as they were for Bocci (and for Fio). For Gold, they were in the way in his seeking of the attentions and approval of the psychiatrist. For him, for Reisman, and for Prescott, only the therapist was important.

In limiting this discussion to but two groups and seven patients, I have presented scanty data. This has been done, obviously, to avoid confusion in the limits of time. I could easily have presented twice as many patient-examples, drawn from the 10 other groups in our study. Even then, however, I should be able to offer only tentatively the following propositions:

1. Neurotic patients drawn from respect-solidarity family cultures, in which the group is valued over the individual and the parental status is unapproachable and fearful to the child, have a less difficult transition to make into a therapy group if the latter values and fosters patient-patient relationships. Such patients today are likely to come from certain lower-class Old World milieus.
2. Neurotic patients drawn from affect-solidarity family cultures, in which the individual is approved for his rôle performances and the parent is seen as accessible and manageable, have a less difficult transition to make into a therapy group if the latter sanctions and induces patient-therapist relationships. Such patients are likely to come from non-ethnic American and Jewish middle-class families.
3. Analysis of the do's and don'ts in the cultures of therapy groups and their relationships to the differential sanctions and taboos in the cultural groups from which patients are drawn may help explain why some patients are initially "good" patients in the therapist's eyes, others "bad." It is possible, moreover, that such phenomena as Oedipal situations, which we think we see re-enacted time and again in the group, may have quite different meanings for the patient from the Old World slums, for whom the father rôle has always been an unattainable don't, and for the neurotic middle-class scion who has played father (and many other rôles) many times but whose overwhelming don't has been to be himself.

SEPARATION OF THE PARENTS AND THE EMOTIONAL LIFE OF THE CHILD *

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IN this paper I shall confine myself to the effects on the emotional development of the child of the prolonged and essentially permanent absence of one parent from the home, and comment only to a limited degree upon those even more unfortunate situations where both natural parents are absent, presumably permanently so. I shall consider only those situations, too, where the absent parent, though away from home, is still living and may or may not be accessible to the child at stated intervals. Furthermore, because of the fact that in 75 to 90 percent of any series of broken homes coming to our attention it is the father of the child who is absent, my remarks will be primarily directed to the effect of his absence on the child's development. To be sure, a certain percentage of mothers do desert their children, or their children are taken from them by direction, and when this happens the basic problems set for the child vary in kind and in intensity; to these I shall lend some emphasis. Yet the prototype of the broken home is that where the father is absent and the mother has the sole care of the children. In the fourth place, I shall not attempt, except tangentially, to outline the different effects of the absent parent on boys and on girls as such. Rather I would select for our consideration some universal effects upon children regardless of sex and some fundamental problems in emotional development that are affected by the absence of the parent.

Specifically, I shall speak of the effects of parental separation upon:

- The child's developing "concept of self"—the ingredients that go to establish his own inner sense of separateness, integrity, worth-whileness, and security as an individual.

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● The child's "concept of human beings" that comprise his outer world—human objects to which he must make a definite feeling orientation and to which he is expected to respond, as a child and later as an adult, in an acceptable and an efficient way. (To the technically minded perhaps it is correct to say that I am directing my attention to the possible effects of parent absence on the ego development of the child.)

We shall begin our discussion by a glance for a moment at what the parent is to the child; *i.e.*, what are some of the most important attributes of the parent as far as the child is concerned and as he or she is seen through children's eyes and feelings at various stages of development. In the light of these many parental rôles (and they are many and complex), we ourselves shall be better able to appreciate the effect of deviations from these rôles which are brought about when a parent leaves. To the child at any age—and particularly in earliest childhood—the parent (both parents) is the source of life itself in the form of food and clothes—the one single factor of basic significance in establishing within him a sense of security and in indicating probable continuing survival. He predicates his physical integrity, including later his sense of anatomical integrity, upon the presence of parents who will care for his bodily needs and will protect him from aggressive and mutilative attacks by others.

To this basic feeling of security of body and its associated concept in the child's mind that parents through their presence alone will maintain it are added other elements in the child's over-all estimate of his parents. They are the givers of gifts that may be used as objects for gratification and the givers of love in and by itself or as symbolized by these gifts. They are in great measure the omniscient givers of information that explains his world and omnipotently protects him in it. In their seeming omniscience and omnipotence also they control his life, direct his behavior, and emphasize ideals of conduct in individual and group living.

These are the elements of the fundamental concept of the parent as it exists in the mind of the young child. Obviously many modifications of this biological or strictly "dependency-need" concept of the parents must take place as the child advances toward the establishment of a necessary concept of himself as an independently (relatively independently, of

course) behaving individual or "self," at which point he is expected to refer his behavior to inculcated or incorporated mental images of these parents which, for good or ill, are to be the most powerful models that he will have within him.

It should be emphasized, too, that these parental concepts will in large part determine what the child's notions of human beings as a whole in his world of the present and the future will be like. The human objects to which he will direct, or from which he will withhold, his love in the expectation of gratifying and satisfying experiences will be determined in large part by his infant and childhood concept of the parent figures. These are models of the human love objects in his environment.

On the other hand, it is not difficult to conjecture that the child's basic concept of self is also determined by the variations in behavior on the part of his parents as they relate to the security feelings mentioned above. His worth-whileness and his intrinsic value of himself as an individual is first, and hence most crucially, demonstrated to him by the expression of his parents' own love, care, attention, protection, gifts, companionship, etc., through their presence (in the earliest years almost omnipresence) in his vicinity. One's concept of one's worth of self is inevitably a product of another's expressed need or want.

If these hypotheses and assumptions of the importance to the child of these parental relationships in the formation of both his concept of self and his concept of human beings are correct, it is possible to examine and outline the effect upon the child of any and all deviations of parents from the most efficient model for which we could hope.

We have selected for consideration one trauma, the deleterious effect of a prolonged or permanent parent absence upon these concepts. These varying effects in varying situations are brought to our attention through numberless clinical observations.

Let us start, first of all, with the child whose parent left the home before the child was two or three years of age. He has, let us say, never seen the father or cannot remember ever seeing him. It is natural for such children, at four or five and thereafter, to note the difference in their own homes; and their questions as to "Where is my father?" or, more point-

edly, "Who is my father?" are either answered evasively or are virtually ignored by the remaining parent. Naturally the mother is in a very difficult position because she is caught in a conflict which she knows she has, in part, and which, regardless of what she answers, she is going to transmit with full force on the child. If she tells the child that the father left because he did not love them, the child himself feels—just as does she—for the first time a sense of worthlessness. He feels that he must have been (and still is) of little worth or his father would never have left. There is, too, a questioning of the absolute worth of his mother, for she too was left. If the mother states that she left the father because they "could not get along together"—thereby trying to minimize the shortcomings of the father in the eyes of the child—the child may very well feel that perhaps his father was all right, perhaps even better than mother really, that mother is keeping his father from him, and that the latter really would like to be home if mother would only let him. In this situation the child's concept of the mother is that she is in some part a depriving mother—depriving him of the love and companionship of a father, not because he, the child, is at fault, but because the mother and father didn't like *each other*.

Assume for a moment that the mother tries to soften the blow by taking it out of the realm of personalities or of likes or dislikes and placing it instead in the area of economics. She states, for example, that father left "because he could not support us," really meaning of course in many situations that "he *would* not support us." Immediately the child's concept of his father, of fathers in general, and of men in general is that they are unable to care for mothers or children and that under such circumstances men in general may leave their children or—even worse—ladies may leave or abandon the fathers of their children. To go beyond this rumination of the child: in the clinical setting it is not unusual for a further equation to be arrived at, namely, if mothers can so easily abandon husbands, they perhaps may at some time, if provoked enough, just as easily abandon the small prototype of husband, the male child, *i.e.*, himself. And this certainly does not add to the child's sense of security, nor does it add to his estimate of his own worth in a world populated by human love objects.

Another explanatory device is based on the assumption that

all such feelings may be prevented if the child is led to believe, through either expressed or unexpressed hints, that the absent parent is dead. This is a solution used more often than one would suppose. By such a technique the remaining parent escapes an expression of her feelings only temporarily, and the child does not escape for long either. Almost inevitably the child learns or has to be told that the absent parent is not really dead; and the acute, drastic, and painful modifications that he must make at that time are equally traumatic, if not more traumatic than the changes in concepts and feelings that must occur in the light of the other explanations commented on above. They involve, too, a marked change in his estimation of the trustworthiness of all human beings. If a parent can lie about a thing so important to him, the parent certainly cannot be trusted in all other explanations which he has received or in the future expects to receive on demand.

There is a specific anxiety that is aroused in the child as he grows older—and particularly in adolescence—following a spurious explanation that the absent parent is dead. As the child begins to doubt this explanation or as he is later given indirect or direct inklings as to the truth, he is tortured by the possibility that he is an illegitimate child: that his father left before he was born because his father and mother were never married or that he was illegitimately conceived and the marriage took place merely “to give him a name.” This is a very logical deduction on his part when the remaining parent attempts to correct the original falsehood by explaining that the father disappeared before the child was born or shortly thereafter.

Finally, there is the possible deduction too—in separations taking place in the child’s infancy and earliest years—that his father and mother got along reasonably well and lived together until he was born. In this situation it is very easy for the child to assume that if he hadn’t been born the parents would be together—that he was the *cause* of the separation. They wanted each other but did not want *him*. One can estimate the child’s own sense of worth as an individual human being in the midst of such logical ruminations. And such ruminations are the only logical ones the child can make in the light of the information that he is allowed to receive in many broken homes.

As I stated above, the mother's position following a separation in the early life of the child is a difficult one when she is asked to explain to the child the absence of the father. My thesis is that there is no explanation that will not have an adverse effect on the developing self-concept and human-being concept of the child. These effects may be and should be minimized, but they probably cannot be entirely eliminated.

Let us turn now to the effects on the child of a separation of the parents at a later stage in his development, placing the separation at a time after the child has received the benefits of an unbroken home and has had the opportunity of forming positive relationships with and concepts of both a father and a mother. I need not tell you that there is usually a long period of strife and discord in the family to which the child is subjected before the separation actually becomes a fact. He has formed to a certain degree a working relationship with both parents; both have satisfied his needs to some extent as love objects, and with respect to each he has formed a definite concept of his own self-worth and also a notion of the worth to him of father and mother—and of the value and worth of adult male and adult female human beings.

The positive aspects of both of these self and not-self concepts come under severe attack during the distressful times preceding parental separation. If the child is inclined to believe or take sides with his mother perforce in her continued and severe devaluations of his father, he may acquiesce, but he does so with poignant feelings of guilt because of the necessary modification of the concept of himself as one who must show expected love of and devotion to his father. The same arousal of guilt is caused as he listens to his father's complaint of his mother and to the citing of her deficiencies as a mother. The "good child" picture of himself that he has constructed for himself as the best source of security obtainable in this world demands that—if he is to remain a "good child"—he must retain his love for both parents. Circumstances just won't allow him to do this.

Even worse for the child is the feeling that his basic and fundamental security may be in large part swept away if either parent leaves him. Both parents are necessary to take care of his needs, the satisfaction of which he has ascribed as being particularly and peculiarly the rôle of one and not

the other parent. Despite repeated attempts at reassurance on the part of the parent who is to remain with him, he is rarely convinced that that parent alone has the power to supply all his needs—and, of course, this intuitive feeling of the child is essentially a correct one and is so proved in time.

When we turn at this time to the other aspect of our discussion, namely, the effect of these devaluative maneuvers and strife between parents on the child's concept of human beings as a whole, we again note some necessary modifications in his estimations of human worth. These are serious and can be far-reaching. For the child the behavior and worth of parents are the models for his evaluation of the behavior and worth of all men and women. Particularly do they constitute the only closely and intimately available model of the expected love of one human being for another and of one man for one woman. The expected and hoped-for stability of love relationships of all persons—including those directed by and directed toward *him*—must be drastically modified at this period. Love relationships with human beings no longer appear sufficiently stable—they may be hazardous and lead to eventual hatred and abandonment. At least the child will henceforth be forced to consider them extremely conditional and capricious, and his reluctance to enter himself into such relationships and his attitudes toward them when he does may be patternized at the time of his parents' separation and lead to considerable future distress.

In short, if one has the opportunity to study a child intensively just before, during, and after parental separation, one is struck by the similarity of the child's reaction to the well-known "grief reaction." He tries desperately to withdraw the emotional investment he heretofore had in the now absent parent and struggles to place it elsewhere in other persons, objects, or interests in his environment. He cannot allow such positive feelings to persist or he feels guilty in respect to his negative feelings or hate for the *remaining* parent. His normal ambivalence toward the parent who has left him is heightened and his guilt becomes greater. To acquire any kind of security and peace he must get rid of both his positive and his negative feelings regarding the latter—and this process, like the mourning process, is a long and painful one.

Following the essentially permanent separation of the par-

ents, other problems arise which in the main are more or less directly related to the possibly changed attitudes toward him on the part of his parents and to the difficulties involved in his attempts to maintain a desirable relationship with both of them—with the present parent in his everyday life and with the absent parent whom it may be possible (or expected of him) to see at stated intervals.

Assume for a moment that the child stays with his mother. Any number of changes may take place in her attitude toward him, and they are easily detectable.

1. For example, he may become to the mother—and he may sense that he has become—a burden. He may be regarded as an economic burden making it necessary for the mother to work both outside and inside the home. Or the fact of his existence and his presence may become to the mother a definite block to her desire for social relationships with adults of both sexes, or to her desire to marry again, or to the carrying out of a previously desired career that had been thwarted by her marriage in the first place.
2. The presence of the child may be a continuing example to the mother of her own deficiencies—notably her failure in her attempt to maintain a home, to satisfy a husband, to be a completely adequate wife and mother. Doubts concerning her abilities along these lines may have existed before her marriage, and its breakup may have confirmed them. The child in turn is a continual reminder and reactivator of these long-existing doubts and fears.
3. Directly associated with these changed attitudes toward the child on the part of the mother is the tendency for her to identify the child with the absent husband, and particularly to identify the child with all the bad and undesirable aspects of the father's make-up. This may happen whether the child is a boy or a girl, though obviously it occurs more often when the child is a boy. Here again the causes may reflect the mother's deep, unconscious, and unrecognized feelings about all males and only secondarily her feelings concerning a particular one—the child's father.

In short, the child may have become an economic burden, a social burden, and an emotional burden to the mother and he begins to realize it. In this situation the child necessarily fears that he is in danger of being abandoned, deserted a second time, this time by the mother. His feelings and his responses when he is seen clinically are those of the terribly insecure and fear-ridden child who in his behavior is attempting all the maneuvers that he can to attain or to maintain what to him seems to be a security position. He may try docility, passivity, and quiet withdrawal to make himself into the "good child" that the mother must love. More often he will fight back with hyperaggressiveness, hostility, and insubordination. He may attempt a regressive move to the behavioral levels of infancy when, he remembers, he was really loved and wanted, or resort to frequent feigned illnesses to regain an attentive response of love and care. Whichever one of these security tactics he may try—and any given child will usually attempt all of them in turn—he usually is unsuccessful in meeting these newly expressed hostile attitudes on the part of the mother.

On the other hand, it sometimes happens that the mother's changed attitude is one of increased positiveness and devotion to the child—and overwhelmingly so. The mother, in her attempts to demonstrate that she is an adequate mother in the face of a separation from the father (with all that this involves concerning her estimate of her own worth) may become extremely oversolicitous and overprotective of the child. His every wish has to be satisfied and his every need gratified in order that her child may appear before the world as a happy and contented youngster. He is figuratively smothered with love and gifts so that the mother may prove to herself and to him that she has not failed and will not fail in her rôle as a mother. In the absence of the father the child becomes the single, all-inclusive libidinal investment that the mother makes, to the exclusion of an investment of any part of herself in other people or other interests. I need not emphasize the harmful effects that such an excessively overprotective attitude on the part of the mother has on the child because, in the first place, of the impossibility of complete reciprocity of feeling toward the mother on his part. Such reciprocity is not

possible in the case of the child in the intact home, nor is it possible when one parent is permanently absent.

You are aware too, I am sure, of the harmful effects of such maternal behavior in relation to the orderly development of the child—to the necessity for eventual separateness and individuality and to the initiation and beneficial completion of those maturity thrusts that depend on the widest possible association of the child with other human beings, both children and adults. And, finally, there is always to be considered the deviated and unrealistic conception of self-worth and self-value that is inculcated within the child when he is the sole object of the mother's love and overprotectiveness.

In short, when this becomes the relationship of the mother and child, the mother's needs rather than those of the child become the real motivating factors in maternal behavior.

There are additional problems set for the child whose parents are separated which, though I shall mention them but briefly, are extremely important in that they may involve the child in acute conflicted feelings resulting in guilt and a consequent modification of his internal notion of his own worth.

The child of the broken home feels "different" from other children. He is continually asked by his colleagues to explain the absence of the parent, to answer the question as to where the parent is, to give judgments to them as to which parent he feels is or was at fault, and to declare which of them he likes the more. In addition to his not knowing the answers to all these factual questions, he is not able without considerable guilt to express his true feelings in the matter. Children in general are particularly curious about broken homes and the causes of them, their curiosity arising, of course, from the possibility—however remote it may actually be in reality—that such a fate may befall their own homes. The child of separated parents is a source of information for them about facts and feelings that they hope may lead to their own reassurance and security, and they can be unwittingly cruel in their approach. At any rate, the child is made to feel "different."

Then there are the conflicted feelings that arise at the time of necessary visits to the absent parent: the child feels guilty if he leaves his remaining parent and he feels particularly guilty if he feels he had a better time there than he ever

has at home. On the other hand, if he does not wish to visit the absent parent, he also feels he is a sinful child. Unfortunately he is subjected many times by both parents—by the one at home and by the one he visits—to expressed or unexpressed hostility toward, and devaluation of, the other parent. He becomes an instrument for each parent to prove that he is the better parent, that he loves the child more, that the other parent's care of him is inadequate and the cause of all his unhappiness and deficiencies in conduct or attainments. The child attempts, if he can, a double, mutually exclusive attitude of love and devotion to both parents, in order to prove to himself that he has two good parents who love him; but he rarely succeeds in this and his attempts are usually transitory and are inevitably guilt-laden.

Such visits to absent parents—their time and duration—are sometimes set by law and occasionally they are badly set. One suggestion that I might make in this respect is that visits, if demanded at all, should not be restricted to occasional single days or week-ends or to one or two holidays a year. Such short visits merely result in compulsion on the part of the parent to shower the child with innumerable gifts, and with attendance at a score of entertainments of various sorts to try to indicate to the child that this is the kind of idyllic life he would lead if he lived there all the time—a much happier existence than he now has in his permanent residence. The child returns home with little or no real appreciation of the real worth of this parent and with no feeling that the parent really loves him for his own sake. Visits should be long enough for the child to appreciate both, and particularly for him to maintain a feeling of really belonging somewhat to the other parent and to feel that there can be a meaningful continuity of this relationship.

In summary, then, I have tried to sketch some of the effects of the separation of parents on the emotional state and on the emotional development of the child. I have confined my remarks at this time solely to the effects of parental separation of any kind where the permanently absent parent is still living, believing that these are some of the universal feelings of children thrust into such circumstances, regardless of the fine type imbedded in various legal documents.

I have stressed the ill-effects of such separations upon the

all-important adequate and efficient "concept of self" and "concept of human beings" that we wish to see formulated in the minds of our children as they mature. For over and above our concern about the immediate insecurity and conflicted feelings of children whose parents are separated should be our equally great concern for a predictable constancy and stability in the love relationships of all people, one for the other.

THE RELATIONSHIP OF EMOTIONAL ADJUSTMENT AND INTELLECTUAL CAPACITY TO ACADEMIC ACHIEVEMENT OF COLLEGE STUDENTS

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IT is widely accepted that emotional adjustment and intellectual capacity are important factors in the academic adjustment and achievement of college students. In many instances the selection of college students is predicated upon their prior academic performance and indications of intellectual ability, with secondary consideration being given to their emotional stability. Attempts have been made to evaluate the importance of this latter factor in understanding the future performance of the student. Among them are Monroe's⁷ study of women students at Sarah Lawrence College by the use of a modification of the Rorschach Test and the American College Entrance Examination. Jacobsen⁵ evaluated the performance of medical students at Washington University School of Medicine using the results from the Minnesota Multiphasic Inventory as well as the Strong Vocational Inventory and Medical Aptitude Test.

These and other studies emphasize the importance and significance of emotional adjustment in the subsequent academic success of the student. However, an important criticism of the personality tests which have been used is that they appear to be uneconomical in time used for administering and scoring for continued use in accessing a large university population.

The purpose of this study is to investigate the relationship of emotional adjustment and intellectual capacity to the academic achievement of college students by using a relatively simple technique of testing and evaluation. The technique could be practical and useful to counselors or to the academic staff in identifying students who may show evidence of maladjustment in campus or classroom living. Another aim is to present results which may be used in forming selective criteria of the probable academic success of entering students.

Methodology

The subjects were divided into two groups who were selected at random from their classes. Group I consisted of 199 male members of the freshman class of Adelbert College. This was the entering class of 1948, which had a total of 297 members. A second group consisted of 154 female members of the freshman class of Flora Stone Mather College of Western Reserve University, also of the entering class of 1948 totaling 193 members. The Rotter Incomplete Sentence Test¹⁰ was administered to all members of the sample and was used to give an indication of emotional adjustment.

The Yale Battery⁴ and the American College Entrance Examination² were used routinely by Adelbert and Mather Colleges respectively to obtain an indication of the intellectual capacity of the entering students. The academic performance of members of the sample was followed for four years, and their entrance test scores were considered in the light of their subsequent academic achievement.

Criteria

The criterion of academic success was the attainment of a passing grade average of 1.0 at the first-year level. Graduation was the criterion of success used at the end of the fourth year in addition to the mean grade score for the class.

The Rotter Incomplete Sentence Blank is a projective technique which yields a numerical score indicative of gross personality conflict. It is not intended to provide ratings in finer diagnostic terms. This test is a revision of forms used by the United States Air Force in the selection of personnel; subsequently it has been used in clinical settings. The use of the incomplete sentence technique dates back to Ebbinghaus, who in 1893 utilized it to test intelligence in children. Subsequent use of this technique in the field of personality has been made by Tendler,¹² Rohde,⁸ and Rotter.^{10, 11} Comprehensive reviews of the historical development are presented by Abt and Bellak¹ and Bell.³

The Rotter ISB is made up of 40 separate items, each consisting of one or two stimulus words. The subject is required to add a sufficient number of words to complete a sentence, and by so doing provides, it is assumed, a reflection of his attitudes

and conflicts. The test requires approximately 30-45 minutes to administer and about 15 minutes to score, according to the manual based on a college population.

The Yale Battery and the American Council on Education Examination are recognized instruments yielding indications of intellectual capacity. These tests have been used routinely in the admission procedure of Western Reserve University.

Results and Evaluation

Correlations of Rotter Test scores and academic achievement for males and females at the end of the fourth year were .01 and .01 respectively. These correlations are in agreement with the findings of Rotter,¹⁰ who states the general feeling that very little relationship seems to exist between intelligence and conflict scores. When related to grades the American Council on Education Examination yielded a correlation of .36. The Yale Battery yielded a correlation of .32 with grades. Because the Rotter correlations were so low, a regression equation approach to the data was not feasible. Scatter plots of the scores in various combinations revealed that the greatest variability occurred in the mid-ranges. Thus, a separate consideration of the quartile scores was thought to be valuable in addition to a study of the middle-range scores.

Initially, mean scores were obtained for all measures and used as cut-off scores. When the Rotter and Yale mean scores were considered separately in their relationship to academic success and failure by the Chi Square Method,⁶ the Rotter scores lacked significance at the first- or fourth-year level. However, the Yale scores were significant, with correction for discontinuity, for the first year at the one percent level in distinguishing between passing or failing. But by the fourth year, the Yale score was less significant in reference to success or failure to graduate.

This raised the problem of identifying factors involved in the lowering of the significance of the Yale Battery score over the four-year period. To investigate the possibility that emotional factors influence the full use of intellectual ability the scores were considered together for each individual in our groups.

To gain information regarding these relationships the

Rotter and Yale mean scores were combined into four groups. When these combined groups were compared with Rotter and Yale scores alone, it was found that of the 15 students who were failing with Yale scores above the mean at the end of the first year, 10 had high conflict scores. Of those found to be below the mean Yale score, 59 were failing by the end of the first year, but here the Rotter score clearly did not differentiate between the groups. At the end of the fourth year in the high Yale group, of 24 who failed to graduate 14 were found to have high conflict Rotter scores. In the low Yale group, however, 43 failed to graduate and 20 out of 50 were found to have high conflict.

Thus, the Rotter adjustment score when combined with the Yale score may be of value in indicating failure in the group in the higher intellectual range. However, when the percentage total losses were evaluated no significant differences were found between the sub-groups. The results of the above suggested the importance of high intellectual ability upon academic achievement.

In order to discriminate further, the Rotter and Yale scores were divided into percentiles and compared with academic standings as shown in Tables 1 and 2. The 75th percent and 25th percent (representing the best and the poorest respectively) were used as cut-off scores; thus 50 percent of the sample were included in these groups.

As shown in Tables 1 and 2, the Rotter scores alone again did not differentiate between success and failure. The Yale scores, however, were significant at the first-year level and

TABLE 1.* ROTTER AND YALE PERCENTILES IN RELATION TO ACADEMIC STANDING IN FIRST YEAR OF COLLEGE. (MALE GROUP)

<i>Academic Standing</i>	<i>Rotter</i>			<i>Yale</i>			<i>Total</i>
	75%	25-75%	25%	75%	25-75%	25%	
Passed	31	53	41	47	58	20	125
Failed	18	33	23	7	37	30	74
Total	49	86	64	54	95	50	199
Percent loss.....	37	38	35	13	39	60	37

* The Rotter 75%, 25-75%, and 25% refer to low, moderate, and high conflict respectively. The corresponding Yale Battery 75%, 25-75%, and 25% refer to relative high, moderate, and low intellectual capacity for this group. (R 75% refers to scores of 121 and below; R 25% refers to scores of 137 and higher; Y 75% refers to scores of 380 and above; Y 25% refers to scores of 261 and below.

TABLE 2. ROTTER AND YALE PERCENTILES IN RELATION TO ACADEMIC STANDING, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (MALE GROUP)

Academic Standing	Rotter			Yale			Total	
	75%	25-75%	25%	75%	25-75%	25%		
Passed	30	49	32	37	54	20	111	
Transferred	8	9	9	8	9	4	21	
Academic Loss {	Failed	8	19	12	5	16	18	39
	Withdrew ..	4	5	7	3	8	5	16
	Military							
	Service ...	4	4	4	1	8	3	12
Total	49	86	64	54	95	50	199	
Percent loss.....	33	33	36	17	34	52	34	

again by the end of the fourth year. The percentage losses were almost identical for both the first and fourth years.

The Rotter and Yale percentile scores were then combined and these groups compared on academic standings as shown in Tables 3 and 4. In these groups the more intelligent low conflict group (I-a) succeeded significantly better than the less intelligent high conflict group (III-c). At the end of the first year there were seven failures in range I, but six of these seven scored with some conflict or were highly maladjusted. In range III there were 30 failures, 22 of them scoring highly maladjusted or had some degree of conflict. In these combinations the students in the group of greater intelligence low conflict (I-a) were significantly more successful than those in the group of low intelligence and high conflict (III-c). Thus,

TABLE 3.* COMBINED ROTTER AND YALE PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING AFTER FIRST YEAR IN COLLEGE. (MALE GROUP)

Academic Standing	Yale I Rotter #			Yale II Rotter			Yale III Rotter			Total
	a	b	c	a	b	c	a	b	c	
Passed	12	16	19	13	30	16	6	8	5	125
Failed	1	2	4	9	19	9	8	12	10	74
Total	13	18	23	22	49	25	14	20	15	199
Percent loss....	8	11	17	41	40	36	57	60	62	37

Significant at the 1% level of confidence.

* The Yale I, II, and III groups refer to the percentile divisions of Table 1 with Yale I indicating the higher intellectual capacity. The Ra, b, c categories refer to the Rotter percentiles of Table 1 with Ra indicating those with least conflict.

TABLE 4. COMBINED ROTTER AND YALE PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD.
(MALE GROUP)

Military										
Academic Standing	Yale I Rotter #			Yale II Rotter			Yale III Rotter			Total
	a	b	c	a	b	c	a	b	c	
Passed	12	12	13	12	31	12	6	7	6	111
Transferred ...	0	4	4	3	3	3	0	2	2	21
Academic Loss {	Failed ...	0	1	4	5	8	3	10	5	39
	Withdrew .	0	1	2	1	4	3	0	2	16
	Military Service..	1	0	0	1	3	4	2	1	12
Total	13	18	23	22	49	25	14	20	15	199
Percent loss....	8	11	26	32	31	40	57	55	47	34

Significant at the 1% level of confidence.

in range I, group "a" is most successful but this does not follow for the "a" group in the other ranges. However, this may be fortuitous because of the small number in our sample.

By the end of the fourth year, the results were substantially the same. The Rotter appeared to be most useful in range I in distinguishing between the groups, since in group I-a there was only eight percent loss as compared to 26 percent loss in group I-c. The percentage of academic loss increased from the first year to the fourth year in groups I-c and II-c. Thus, it would appear that the Rotter scores were of value in indicating the impact of emotional conflict upon academic achievement when viewed in combination with intelligence in this highest range. In ranges II and III the Rotter score did not discriminate between the groups. Within range I the Rotter scores were able to distinguish between the groups and indicated a consistent progression of loss from I-a to I-c at both the first and fourth year. Further, the percentage loss in group I-c increased by the fourth year from 17 percent loss to 26 percent loss.

Additional information was obtained when the mean of the grade point average was matched against the Yale and Rotter percentile scores as shown in Tables 5 and 6. When this was

TABLE 5. COMBINED ROTTER AND YALE PERCENTILES IN RELATION TO MEAN POINT AVERAGE FOR FIRST YEAR IN COLLEGE. (MALE GROUP)

Academic Standing	Yale I Rotter *			Yale II Rotter			Yale III Rotter *			Total
	a	b	c	a	b	c	a	b	c	
Above Mean....	12	14	15	9	22	11	1	2	3	89
Below Mean....	1	4	8	13	27	14	13	18	12	110
Total	13	18	23	22	49	25	14	20	15	199

* Significant at the 1% level of confidence.

done, the significant finding was that the groups in range I still differed. At the end of the first year, in range I, 41 students out of 54 obtained grades above the mean; in range II, 42 out of 96 scored above the mean; in range III, only six out of 49 scored grades above the mean. This would indicate the effect of intellectual capacity in academic performance. In range I, group I-a (low conflict) had only one student with a score below the mean, while in group I-c (high conflict) there were eight students below the mean. This seems to support the above results that the Rotter is of value in discriminating loss in the higher intellectual level.

TABLE 6. COMBINED ROTTER AND YALE PERCENTILES IN RELATION TO MEAN POINT AVERAGE, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (MALE GROUP)

Academic Standing		Yale I			Yale II			Yale III			Sub-total	Total		
		Rotter			Rotter			Rotter						
		a	b	c	a	b	c	a	b	c				
Passed	A	9	10	11	4	11	4	0	1	1	51	111		
	B	3	2	2	8	20	8	6	6	5	60			
Academic Loss	Failed...	A	0	0	0	0	1	0	0	0	0	1	39	
		B	0	1	4	5	7	3	3	10	5	38		
	Withdrawn	A	0	0	1	0	0	1	0	0	0	2		
		B	0	1	1	1	4	2	3	0	2	14		16
	Transferred.	A	0	2	3	0	0	2	0	0	0	7		21
		B	0	2	1	3	3	1	0	2	2	14		
	Military Service	A	0	0	0	0	1	1	0	0	0	2		12
		B	1	0	0	1	2	3	2	1	0	10		
Sub-Total	A	9	12	15	4	13	8	0	1	1	63	199		
B	4	6	8	18	36	17	14	19	14	136				
Total		13	18	23	22	49	25	14	20	15		199		

See Tables 3 and 4 for explanation of terms.

A—above mean grade point average.

B—below mean grade point average.

At the end of the fourth year, the results appeared to follow the same trend, as indicated in Table 6. In range I, the differences between the groups above and below the mean (A and B respectively) were found to be not statistically significant. In the category of academic loss, group I-a lost only one—and that student to military service. Group I-c, in contrast, had ten students who were lost to the school for various reasons. In ranges II and III only chance differences were found. Characteristically, those who failed to graduate by and large achieved grades below the mean point average. In the transfer group seven (33⅓ percent) scored above the mean for the class, but the majority of these were located in range I.

TABLE 7. COMBINED ROTTER AND YALE PERCENTILE SCORES IN RELATION TO FAILURES PER SCHOOL YEAR. (MALE GROUP)

School Year	Yale I Rotter			Yale II Rotter			Yale III Rotter			Total
	a	b	c	a	b	c	a	b	c	
1st	0	1	0	1	1	2	0	5	2	12
2nd	0	0	2	1	2	1	2	3	1	12
3rd	0	0	1	2	5	0	0	1	0	9
4th	0	0	1	1	0	0	0	2	2	6
Total	0	1	4	5	8	3	2	11	5	39

See Table 3 for explanation of terms.

This would lend credence to the view that some highly endowed students may transfer to other schools offering more personal opportunity. Among the 21 transfers only 3 students were found in the "a" groups (Table 6). This trend holds up in an examination of the other academic categories of loss where fewer students were found to be in the "a" (low conflict) category. Also, those students who left school for various reasons by and large are those who had grades below the mean point average.

Analysis of the failures over a four-year period (Table 7) revealed that the greatest number of failures (24) occurred within the first two years of college. In range I only one student failed at the end of the first year who falls in group I-b. The other failures occurred in group I-c during the remaining three years. Significantly, there were no failures in this range of those who were adequately adjusted (I-a). In range II, five failures in 16 occurred in group II-a. All the failures

in group II-c failed by the end of the second year, while those in groups II-a and II-b managed to stay in school for a longer period before dropping out. Findings in range III show that the more adequately adjusted group had two of the total of 18 failures. Again, the greatest number of failures occurred within the first two years. Summarizing the failures, only seven out of 39 (18 percent) were adequately adjusted in contrast to the remaining 32 (79 percent) who had some degree of conflict; moreover, of the total of 39 failures 31 percent had what was considered a high degree of conflict.

From the above findings with the male group, the most pertinent data seems to be obtained from the percentile groupings. The most successful group of students was that scoring both with high intelligence and low conflict. In the category of academic failure the smallest loss appears in the adjusted groups, which is also found to be true in the transfer and withdrawal categories. Delineating the above groups of well-adjusted students for selection to college does not imply exclusion of all other students from admission, but rather the identification of those who would profit from some additional assistance in order to better benefit from their academic experience. Such help could be forthcoming from faculty advisers, a counseling service, and psychiatric consultation.

The female group scores were arranged in the same manner as discussed above. Comparison of the Rotter and the American Council on Education Examination mean scores with academic success and failure showed no statistically significant difference for the Rotter scores. This was the same finding as obtained in the men's group. When the combined scores were used, the Rotter was able to distinguish between success and failure among those students who scored in the lower intellectual range. There were two and one-half times as many failures at the end of the first year of those who achieved Rotter scores indicating conflict. However, at the first-year level there was no distinction between the high intelligence groups.

At the end of the fourth year, the groups with better adjustment met with greater achievement than those with poor adjustment within the entire range of the intelligence score.

The percentile combinations were considered as in the male group (Tables 8 and 9). The results at the end of the first

TABLE 8.* COMBINED ROTTER AND A.C.E. PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING AFTER FIRST YEAR OF COLLEGE. (FEMALE GROUP)

Academic Standing	ACE I Rotter			ACE II Rotter			ACE III Rotter			Total
	a	b	c	a	b	c	a	b	c	
Passed	7	13	11	25	35	19	5	7	2	124
Failed	1	1	1	4	5	7	0	10	1	30
Total	8	14	12	29	40	26	5	17	3	154
Percent loss....	13	7	8	14	13	27	0	59	33	19

* ACE groups I, II, and III refer to the relative intellectual capacity of the sample with ACE I including scores at the 75%, or 140 and higher; ACE III refers to the 25% lower group with scores of below 102; ACE II includes all in the middle range. The Rotter a, b, and c groups are the similar percentile levels with Ra having scores of low conflict, those below 112. Rc includes high conflict scores of greater than 140.

year were inconclusive. However, the well-adjusted higher intelligence group did consistently better than all other groups within the ranges by the fourth year. The well-adjusted group in each range did better than all other groups. Although there were fewer students in the female group, the trend seemed to be similar to that found in the male group. Also, there were fewer well-adjusted students among those who failed to graduate. Thus, the Rotter adjustment score seemed to be able to indicate those students who would be likely to have difficulties and thus provides an opportunity to identify and assist them.

In Table 10, the failures in the female group were consid-

TABLE 9. COMBINED ROTTER AND A.C.E. PERCENTILE SCORES IN RELATION TO ACADEMIC STANDING, CUMULATIVE TOTALS FOR THE FOUR-YEAR PERIOD. (FEMALE GROUP)

Academic Standing	ACE I Rotter #			ACE II Rotter			ACE III Rotter #			Total		
	a	b	c	a	b	c	a	b	c			
Passed	4	6	6	20	23	13	2	7	1	82		
Transferred ...	3	1	1	3	11	3	2	4	0	28		
Academic Loss	{	Failed..	0	1	1	1	3	4	0	4	1	15
		With- drew..	1	6	4	5	3	6	1	2	1	29
Total		8	14	12	29	40	26	5	17	3	154	
Percent loss....		13	50	42	21	15	38	20	35	66	28	

Significant at the 1% level of confidence.

TABLE 10. COMBINED ROTTER AND A.C.E. PERCENTILE SCORES IN RELATION TO FAILURES PER SCHOOL YEAR. (FEMALE GROUP)

School Year	ACE I Rotter			ACE II Rotter			ACE III Rotter			Total
	a	b	c	a	b	c	a	b	c	
1st	0	0	1	0	2	3	0	3	1	10
2nd	0	0	0	1	1	1	0	1	0	4
3rd	0	1	0	0	0	0	0	0	0	1
4th	0	0	0	0	0	0	0	0	0	0
Total	0	1	1	1	3	4	0	4	1	15

See Table 8 for explanation of terms.

ered. Here there was only one failure in an individual with good adjustment. Forty percent, or six out of 15, occurred in individuals with a greater degree of conflict. The majority of failures again occurred at the end of the second year. Thus, the trend of failures occurring in those individuals with emotional maladjustment is the same as seen in the male student group.

Summary

The Rotter Incomplete Sentence Blank along with two measures of intellectual capacity were administered to 199 males and 154 females, all of them students of Western Reserve University. The tests were given in their first year at school and compared with grades achieved at the end of the first and fourth years.

Correlations of the grades and test scores were low and scatter plots revealed greatest variability in the middle ranges. Conclusions were derived by analyzing the relationship between the percentile test scores and academic grades achieved at the end of the first and fourth year.

[The study seems to bear out the general assumption that students with high intellectual capacity and an adequate personality adjustment achieve higher academic performance. Those students who indicate deficiencies may be observed from the onset of their college careers and given the benefit of additional counseling, if necessary, as indicated by their first year grades and test scores.]

Because failure in the first year seems to parallel fourth-year performance, the importance of early counseling should not be minimized. (The well-adjusted groups in all ranges—

particularly in the highest intellectual range—do better academically than those with conflict. In terms of selection for college, since the lower 25 percent is not as promising a group as the others perhaps fewer in this range should be selected. Within the upper ranges of intelligence the better adjusted student faces less likelihood of subsequent failure.

Consideration of the combined tests is of value in discerning students of good intelligence and high conflict who will not profit from their college experience as much as those with a better degree of adjustment. The possibility of helping these students capable of academic success is increased by this recognition. Awareness of the presence of highly endowed students who are likely to have difficulty because of emotional maladjustment provides an opportunity for faculty advisers to assist them.

In the remaining ranges of intelligence less difference is seen between the groups, but there seems to be some tendency towards better performance in those with better adjustment. This was seen more prominently in the female group and seems to be better borne out in the analysis of failures, withdrawals, and transfers. Here it was seen that there are fewer adequately adjusted students in these categories. The study further emphasized the importance of intelligence as the factor bearing the greatest weight upon future academic success.

The value of recognizing that emotional factors in students contribute to failure or academic loss is certainly apparent, and it is sound economy to employ measures to diminish this loss. This is important not only because of the financial investment made by the school, but also because of the loss to the community of those who may be potentially more valuable for having completed their college training.

It should be emphasized that selection for admission to college in itself is not the primary aim of this study. The study also provides a measure to indicate the potentially maladjusted students. These should be provided with proper guidance so that they may be able to continue successfully in school. This would be especially applicable to students who are meeting with failure or who are not realizing their intellectual potential to the fullest extent.

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THE TRIALS OF NORMALCY

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SINCE Clifford Beers first wrote *A Mind That Found Itself*, that classic and original best seller among the psychiatric autobiographies, we have been largely concerned with the mentally ill. That has been all to the good. For in many ways the care of the mentally sick was miserably inadequate, and in numerous respects quite disgraceful. During all this time, however, the vastly greater portion of our population, the so-called normals, if not entirely neglected, has been overlooked. It is true we have had a mental hygiene movement which concerned itself with mental health as well as with mental illness. But for all its valiant efforts, its effects have not been great. For most of us seem to operate in the belief that when you are sick something should be done about it, and quickly too. But when you're normal, why that's all there is to it.

Now let us agree that you *are* normal. Can you then take it for granted that life will always run smoothly for you and that you and yours may properly expect, as the fairy tale phrases it, to live happily forever after?

Naive as this may seem, quite a number among us, especially the younger ones, entertain just such expectations. As a result, when things do go wrong, we are astonished, bewildered, and hurt. We are prone to feel that life has been unfair to us. But the crucial trouble is not with life but rather with us, in that we think only the mentally ill have problems. In fact, however, all of us do. Normal people have normal problems, in normal experience. That needs to be underscored many times over. And furthermore we need to understand what these problems are likely to be, when they are prone to arise, why they come into being, and how we can best deal with them. But above all we need to understand that normal people, in normal experience, do have normal problems. Why stress this so much? Because we have long been the victims of a foolish fiction. We have had a romantic, unrealistic vision of normal life as an untroubled, smooth-sailing voyage on the high seas

of experience. But that's nonsense! Nothing in reality supports this picture—foisted on mankind by the sickly, juvenile, French romanticist Jean Jacques Rousseau. It was he who gave rise to the fiction of the "noble savage," and it was he who enthusiastically and persuasively preached the corrupting sermon of a sweet and reasonable naturalism. Others after him took up his roseate beliefs and compounded them into a completely false scheme of life. Life, they argued, is inherently logical, reasonable, smooth, harmonious. It should unfold as untroubled and untroubling as the sweet breath of the gentle spring. It is not life that troubles man, they insist, but man that troubles life. Many among us have been taken in by this wishful thinking, propounded by a sensitive and gifted genius who, unable to face up to the actualities of the living experience, fictionally reshaped the scheme of things closer to his heart's desire. But wishful thinking little affects the reality. And the reality reveals that the living experience affords us great adventures, all of which, however, are beset with many problems.

We come into this world in a turmoil of strife. Some psychiatrists make a great deal of the adventure of being born. They refer to it as the *birth trauma*, and trace to the travail of being dispossessed from the sheltered confines of the womb many of the emotional disaffections of later life. Being born is a trying job, no less for the infant than for his mother in labor. But one need not go to the extreme of swallowing whole the fine-spun theories of the birth trauma. On the contrary one can fancy that during the last months of pregnancy the foetus would find its quarters rather cramped, and thus would be eager to get out where it might stretch a bit. But however one may fancy the adventure of being born, it is certainly not free of problems. Nor does it end on delivery. On the contrary, every step thereafter in the complicated process of growing up confronts the individual with numerous challenges and a variety of problems. For, inherently, growing up, and the living process in general, cannot be pictured as a smooth line of progression, following a wave-like pattern. Actually it is full of reversals, of contradictions, and diversions. It is zigzag rather than smooth. Its logic and pattern is over-all, rather than manifest in each step. Think of the infant driven out of its Garden of Eden, the womb, into the strange and be-

wildering world of the multiform sensations. Before it can become reconciled to its loss there comes upon it the awareness of its mother, a strange person, but soft and warm and pleasing in a variety of ways. The world which first assaulted it with its harsh textures, its unyielding hardness, its noises, bright lights, and changing temperatures, soon yields most interesting patterns. Faces in time take shape, and generally they are smiling, benevolent faces, faces which induce and call forth smiles and gurgles. Touch, too, somehow is molded into caresses and meaningful movements. Strong hands handle you and accomplish wished-for changes. And thus, in many ways, life beyond the womb proves pleasant and rewarding, and the Garden of Eden is almost forgotten. The future, if the infant has any but an indwelling awareness of things to come, must seem to it assured and lovely. But then the adventure is diverted by the advent of unanticipated and most often unpleasant experiences. We can not count them all, but there is solid food in the place of the warm flowing nourishment, toilet training, the seemingly foolish impulsion to stand up, which yields only bumps and bruises, sharp edges that cut, heat that burns, and so on. Worst of all, and all too soon, that creature known as mother, she whom we have come to love more almost than our own sweet selves—she betrays us. The love and attention that she bestowed upon us, that surely was ours by right, she now bestows upon others. The usurper may be that overwhelming creature we thought to be our friend, and whom we heard called father. Or worse still, because it is usually preceded by a mysterious and gradual withdrawing, capped by an inexplicable disappearance of our beloved—the usurper may be a tiny, ugly, squeaking creature that for God-knows-what reason our mother has brought back to live with us. Ugh!

The sophisticated will recognize in this hasty sketch of the infant's adventures the advent of two trying problems—that of the Oedipal complex, and that of sibling rivalry—both, be it noted, normal problems in normal experience. Our intent, however, is not to trace here the full pattern of the individual's adventures in the living process, but rather to underscore the fact that those adventures are not consistent nor logical, but involve rather sharp changes and abrupt reversals. As we go on from one stage of life to the next there are always new

things to be learned and old ones to be unlearned. The latter is all too often the harder task.

Freud has described the young child as a polymorphous perverse creature. The child is in fact natively uninhibited and unashamed. That it might live in and be accepted by society it must be taught to control its impulsions, to curb its curiosities, and to defer its gratifications. But then when it comes of age, the child, grown man or woman, must unlearn the lessons of its childhood, must know that what was heretofore disallowed is now permitted, that what in time past was deferred may now be fulfilled, that what was in such devious ways and for so long repressed must now be realized. Unfortunately, far too many cannot entirely unlearn the lessons of their childhood, and their adult lives are haunted and frustrated by the taboos and inhibitions acquired in childhood.

Here again romanticism rears its befuddled head, for some, who have seen the trials of those who could not meet the demands of adult relations, have resolved to spare their children the risks of such failures by imposing upon them few restrictions and few inhibitions. In most instances this results only in a "jumping out of the frying pan into the fire." As any psychiatrist of experience can attest, the uninhibited neurotic is the most difficult to treat and to help.

The logic of the situation calls neither for crushing repressions nor for uninhibited freedom. What is needed is doing the immediately necessary with an eye to the future reversal. This is a pat phrase, the meaning of which is not easily grasped. Yet that is precisely what is reflected in the affirmation that normal individuals normally confront normal problems in normal experience. All this is best expounded in terms of actual life situations. Let us consider the adventure of falling in love and marrying. Here is a strictly personal experience rooted in one's innermost emotions. The average person in love not only surrenders to the feelings of love, but does so without the least doubt or misgiving but that "as it is now so will it be forever and anon." Of course there are the cynics and the doubters. But for the moment let us exclude them from our deliberations. Besides, most of them are cynics and doubters not because they are wiser but rather because they have imbibed the vinegar of frustration rather than the sweet wine of romance. Now, it is most desirable that those in love

should yield wholeheartedly to their gentle madness. But somewhere in their intoxicated spirit there should be present a sober and rational iota to warn them that love is the beginning of greater things to come and not an end in itself. Unless this sober iota is present and effective—ahead lies trouble. Far worse than too brief a honeymoon is one that outlasts its normal span. The individual, man or woman, who seeks to linger and will not get on with the adventure of living courts disaster. Yet assuredly the most certain, the most unquestionable, persuasion of the lover's heart is that he loves his sweetheart and wants her, for herself, for himself. He has but little awareness that behind this so personal and so intimate emotion there operates a transcending purpose, that of bringing new life into being. Yet sooner or later he, and she, too (though it is easier for her since she has an intuitional awareness of the meaning of all this seldom given the male), must face up to the fact that the private love which enticed and bound the twain must be extended to embrace children, friends, the community, and, ultimately, society. Here too we have come upon a host of normal problems in normal experience. It is no easy task to surrender the woman one loves even to one's infant son or daughter, nor to do with less of service, comfort, attention, leisure, and privacy than one had learned to expect. It is no whit easier for the woman to learn the art of serving two masters at once, and of appeasing the demands of two so very self-centered beings as an infant child and a jealous husband. And then just about the time when a balance of powers has been established and a familial *entente cordiale* created, the hard-won equilibrium is likely to be disturbed by a new arrival. And how, pray, do you do justice to the new without doing injury to the old? The first child is a challenge, the second also, and so is the third and the fourth—each in its own and rather unique way. If their arrival creates problems, so does their growing up, and their trial flights, as they sprout their wings in preparation for taking off on their own.

These are the rewarding adventures of fruitful living. But they bring in their wake a host of problems: the normal problems in the normal experiences of normal people. They should be expected, anticipated, understood, and mastered. All this implies a knowledge of what might be termed the psycho-

physiology of normal experience. It differs from psychopathology, which deals with the diseases and disturbances of the psyche. In some ways it differs also from mental hygiene, for hygiene has traditionally concerned itself with the prevention of disease.

The psychophysiology of normal experience implies something more subtle and yet more fundamental. It bears on the better and fuller living of life. It suggests a degree of insight and sophistication which should enable one to yield to the immediate adventure in experience and yet not to be taken in by its blandishments. Off in the not-too-remote future one should perceive the inevitable change, and be ready to meet it without, however, compromising the present, or dampening the enjoyments thereof.

Is this then a new art to be mastered, a new wisdom to be gained—this psychophysiology of normal experience? In some ways, yes, though historically it is an ancient art, and an ancient wisdom. The best, and in many ways the most fitting, analogy to the psychophysiology of normal experience, is the recently developed science of nutrition. Nutrition also was an ancient science. Hippocrates, the great physician of ancient Greece, traces the origin of medicine to the study of foods, to the observations of which nutriments favor health and which are debilitating, which relieve certain symptoms and which aggravate them. But the science of modern nutrition is radically different from that envisaged by Hippocrates, and part of the reason for that derives from the difference in our foods and in our food habits. The world in the times of Hippocrates, and for many centuries thereafter, was and remained simple. Most of mankind lived "off the earth." Foods were not preserved, stored, refined, and in general treated as we today do and must treat ours. Let me not be misunderstood. The average individual in our part of the world is far better nourished than ever was the ancient Greek citizen or slave. But to be better nourished our people need not only the foods available but the guidance also of the science of nutrition. Such, too, is the case with what we have termed the psychophysiology of normal experience. When families lived in homesteads, with three or more generations in close proximity, the very experience of living together was profoundly instructive. One did not require a course in domes-

tic science, home economics, or child care to prepare for domesticity. One learned that, as one acquired one's mother tongue—by exposure and functional practice. One also acquired insight, wisdom, one might say, as well as knowledge; for one had before one's very eyes a panorama of life in all its stages. But the homestead is gone, and fortunate are the generations that live within phone-call distance of each other. The structure of the family has changed most radically. Neither the position of the woman, nor that of the man, nor that of the child, is what it had been even three generations ago. The woman has been radically dislocated in the familial scheme, but the child even more so. Time past, as soon as the youngster had the requisite strength it was assigned its chores. Thereby it acquired not only a sense of functional belonging, but also some insight into what is involved in keeping the family going. Nowadays for many youngsters, especially for those living in cities, there are no chores to perform; at best there are errands.

The social scientists are much concerned with these problems, and to them we must leave the more special exposition of them. Here we need only call them in witness of the need for an understanding of the normal problems of the normal individual in normal experience. For even if you are normal (and why should we assume anything else?) you will have your problems to face and to resolve, and you will do that more effectively the better you understand them.

THE PATIENT IN A HOSPITAL SETTING

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THE study and evaluation of the patient in a hospital setting can be fully appreciated only as the home is better understood. Since getting the patient well is the all-important function of the hospital, it was thought advisable to study such a home situation so as to use this data in his recovery program.

From the cases known to us, an average patient who was ill enough to be hospitalized was studied. This patient accepted his illness, believed with time and care he could easily get well, and saw no reason to be transferred to a hospital. He felt he was giving up too much to go to any hospital: he was among his loved ones; their smiles, their actions showed respect and reverence for his every wish. He found when he was ill he got even more consideration than any kindness he might have conferred on his family; there was, therefore, every temptation to stay ill so as to be the recipient of the many favors which members of the family might vie with each other to give. This feature he shared with no one as he would have to do in a hospital. His bed was his own, he felt comfortable there, and there were many little things around the house he could still use as he saw fit. All these made hospitalization less inviting. If he went to the hospital, he would have to get another doctor to whom to relate his illness, and even then he did not think he would feel free to discuss everything to a stranger. He had extreme confidence in his physician and, while he respected his doctor's concern for his health, there was a secret feeling that either the doctor underestimated his own ability to help him or just wanted to be rid of him. He could also foresee being among other people whose conversations about their illnesses might force him to think more about his own illness and thus increase his worry.

Studies carried out by nurses and house staff through the years completely enabled us to meet these objections. The patient was assured by his own doctor that he would be visited whenever he so desired and that the doctor-patient relation-

ship *per se* would not be interrupted but rather enlarged for a while. The nurse who first met the patient and his family warmly greeted them. She gave assurance to the family and the patient separately that every effort would be made to make him comfortable and cheerful during his stay in the hospital. The nurse in turn talked to the family to get a bird's-eye view of the idiosyncrasies of the patient so as to understand him all the better.

Placing the patient in the right bed on a ward is always a difficult task. The nurse from her knowledge of her ward community tried to put the patient beside two other patients with whom he could get along easily. The patient was next introduced to his bed neighbors so as to make his area as cheerful as possible. Since patients often request changes, the resident in conjunction with the head nurse may decide that removal to another area may be to the best interest of the ward community. This patient was no exception; he soon developed a great dislike for one of the patients beside him, and at his request was removed to another area. He nevertheless maintained a very close association with the other patient who formerly occupied the other bed beside him. He found his new area more to his liking, closer to the bathroom and to the radio — features he enjoyed at home.

To assure the patient of privacy when he so desired he was advised he could use the curtains around his bed at any time.

A nurse is assigned to several patients and the same is true of the house staff. The patient thus gets the feeling he has his own nurse and his own doctor, in spite of the fact that the doctor and nurse may administer the entire ward. In addition, this helps in arranging programs and carrying out social contacts that would hardly be possible otherwise. Such was the situation to which the patient was subjected.

The patient was also questioned daily not only about his illness, but about any situations that might occur that would make hospitalization unpleasant or pleasant. Doing this prevented him from building up prejudices. At the same time, the nurse explained the ward rules, and explained why when many people live together it is necessary to establish rules for the common good of all. Acceptance of this was much easier than anticipated.

Food was a difficult problem, since at home anything desired

could be had. In the hospital pattern this was not so. Nevertheless, logical explanations were given as to the need for a balanced diet, as we know it, in terms of carbohydrates, proteins, and fats. This too was accepted without difficulty. Soon there was little concern about diet. The fact that he could get some of the things he specially wanted made the problem all the easier.

The patient was in the habit of talking to his doctor about his medications, about what they were for and what was expected. This explanation was offered even before the patient could bring up the question. He was thus happy to be so treated, and felt he was participating in his own therapy. The patient was also prepared for psychotherapy by being told of its aims and purposes and how it was very necessary for him to cooperate. The fact that he was treated in this manner made him all the more willing to discuss his problems with his physician. The opportunity to talk out his problems, to mix with others in group therapy, to be able to relax and play games with others, and to have sympathetic care and understanding from the nurse at the bedside, or her willingness to listen or be a big sister, all helped in his total push for recovery.

As the patient was speeded towards recovery, the family was brought back more fully into the situation so as to be prepared to accept the patient. The patient was also prepared to meet his family again. This was done by physician, social worker, and nurse as a team, each carrying out a specific task. When through conferences the task was considered completed, the patient was once more discharged to his family and his community.

Before discharge, the patient was asked by the head nurse to register any complaint he might have. His only comment was that he was never better treated anywhere. He expressed a desire for periods of seclusion just to think. It was pointed out that in a psychiatric setting this was not always possible unless the patient was advanced to the point of discharge, and then he would scarcely want to be alone. It was nevertheless felt that something deeper was behind this statement: the patient wanted to be allowed to think through in silence certain situations in therapy. The seclusion room was suggested as such a place, but this only partially met such a need.

The patient reported that he missed home only the first few days and that the nurses took over so completely that he was thus in the best of mood when his physician came to assist him.

In all he regarded hospitalization as a most wonderful experience.

Comment

The task of treating the mental patient as a person means marshaling around him all the social forces so as to give him a lift and thus build up ego strength. This factor and its relation to illness has been very well noted by Alexander.¹ The importance of the nurse in this setting cannot be overstressed, for as Lapham² has pointed out: "She is with the patient for hours on end." He has pointed out also that all too often a nurse is called from the case after a day because of incompatibility of personalities; our observations bear out this experience. Good nursing care greatly enhances recovery from every angle.

The importance of team-work and the participation of attendants in team-work is an essential feature in the care of these patients. This was noted by Anderson³ who believed that in some way skill noted at these levels should be passed on to the highest nursing level.

Bennett and Eaton⁴ have noted the tremendous value of the nurse in the new therapies, a rôle which we have observed as nurses are given this opportunity, and a point also expressed by Dix⁵ and Mellow.⁶ It was observed that when the ward was stable and the patients occupied or allowed to mix freely, the rate of improvement seemed greater than when the ward frequently became upset. The desire to keep a quiet and stable ward definitely promoted recovery. This has been noted by Boyd⁷ and Greenblatt.⁸

Finally, there is the task of returning the patient to his home. The method of terminating his care is most important if the patient is not to feel he is no longer wanted. There must be general acceptance that the patient has been given maximum care and that he can now be discharged. This has been stressed by Lorand⁹ and Stekel¹⁰ and borne out by our own experience.

In our setting, therefore, we try to reproduce as well as possible psychological, emotional, and to some degree physical features familiar to the patient so that his transfer from home to hospital is minimally traumatic. It is our experience that such an atmosphere — created by a team of doctor, social worker, nurse, psychologist, and attendant — permits a greater and a more rapid recovery of the mentally ill, and makes the follow-up immeasurably easier. Knowledge of the home, therefore, proves to be of great value, not only in managing the individual case but in handling various cases in an open ward. This attempt to treat a person who is ill, rather than a disease, not only helps the patient but shows all who participate in this care the great interdependence of services and the value of a team in the hospital.

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SILENT PARTNER IN MENTAL HEALTH *

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PERHAPS you know that the growth of mental hygiene, at times a saga of glory and human greatness, is more frequently written in man's blood and suffering. We are so accustomed today to enjoy a democratic way of life, in which human life and dignity are given high valuation, that we may tend to forget the centuries of stigmatization, torture, derision, and neglect to which human emotional problems were exposed. It may be difficult for us to realize that the release of the mentally ill from chains, their care in fine institutions, and the advent of effective systems of treatment are matters of comparative recency.

One need only examine within himself the human tendency to conform closely to a prevalent attitude of a particular time in civilization's history to realize the heroic steadfastness, the foresightedness, the self-effacement, of those intrepid men and women who fought bravely and successfully to bring to our culture realization of the human ethical principles concerning man's humanity to man. The greats of history are not those whose performances lay within the sphere of prescribed and formulated patterns of behavior; the greats have been the dedicated souls who have seen beyond the obligations of a particular moment, who have been gifted with sympathy and understanding for their fellow men, and who have possessed a quiet genius capable of visualizing a social panorama projected into a future in which the welfare of man is a way of life.

The development of the mental hygiene movement follows a pattern not unlike that seen in other areas of human service. We all know that the skilled, technically competent, and highly

* Address presented at a Mental Health Luncheon sponsored by the Philadelphia Junior Chamber of Commerce on May 12, 1955, in honor of psychiatric aides of Embreeville State Hospital, Philadelphia State Hospital and the VA Hospital at Coatesville, Pa., who won NAMH Psychiatric Aide Achievement Awards for Outstanding Service in 1954.

qualified physician of today evolved from the superstitious, ignorant, and often brutal barber of many years ago. The very able, beloved, and well trained nurse of this day represents a tremendous advance in development from the socially unaccepted and unrecognized camp-follower of days gone by.

I believe we are witnessing today a stage in the progress and advancement of another profession. From what once was described as a motley crew of people of questionable social adjustment who chose to care for the mentally ill not through talent but through necessity, we are now seeing in ever-increasing numbers the emergence of highly competent stalwarts like the men we are privileged to honor today. Coming from out of a barren and ignominious past such men and women pave the way for those who must follow after them into the relatively uncharted territory of non-professional psychiatric services to the emotionally needy. These men and women are the Columbuses, Balboas, and Rogers and Clarks of the mental hospital wards. They are map-makers, creators of standards, and leaders in the formation of social ideals.

These are the men and women, sickened by glimpses into the past, who develop and exemplify modes of human relationship that will brighten the future.

It may be well at this juncture to consider for a few moments the importance of the psychiatric aide in the overall treatment program of mental institutions. Of late we have heard so much about the value of "miracle drugs" and of penetrating and effective psychotherapies which are in use in all enlightened institutions that we are inclined to conclude that the only important work contributing to the recovery and well-being of psychiatric patients is that done by the professional members of the staff—the doctors, nurses, psychologists, and social workers. There is no question, of course, of the importance of their work. We know that man's most profound comprehensions of the human psychological structure and the capacity to change it in its unhealthy aspects are scientific acquisitions of less than three-quarters of a century. We know that the physical therapies that require the close cooperation of the physician and the nurse are of inestimable value in the welfare of the many thousands of people who have had, are now suffering from, or will develop mental disorder. We are inclined to think that the magic

therapeutic agent applied at the flood tide of opportunity manages of itself, in a few moments of the patient's life, to promote enduring and desirable changes.

In actuality the true picture of therapy of the mentally ill within the hospital is quite different. The contact of the physician and even the nurse with the patient is an all-too-short and fleeting experience to him. This is owing in part to the well known shortage of psychiatric personnel and the excessive demands on their time. But the real follow-up care, the real ongoing and continuous personal relationships with patients that exploit for the good the momentary treatment efforts by professional personnel, are in the province of the daily activities of the psychiatric aides.

Of course, just as these may be forces for good, sometimes they may be forces for evil. The work of professional personnel may at times be undone by attendant personnel who are disinterested, indifferent, or malevolent toward the patient and his problems. In such cases the fine work of professional personnel may be reversed. This may, in some instances, account for certain therapeutic failures.

In great measure the psychiatric aide must maintain and extend the therapeutic gains achieved by the psychiatrist, nurse, and co-workers. The aide remains in intimate contact with patients. He serves them. He is their companion. He may be the recipient of their tales of woe or the target for their anger. Whatever the particular emotional needs of the patients, the aide is expected to meet them. We often speak of the work of the aides as ancillary or adjunctive in a psychiatric program. I think we may find that in a very large number of instances the aide is the primary therapeutic agent, and he can be a highly significant influence in the lives of his charges.

What is the psychiatric aide? First of all he is *a member of the community*. He is a representative of the social environment from which all too often the mental hospital has become isolated, both by walls of brick and mortar and walls of prejudice and stigma. The aide brings into the ward with him the philosophy of the external society. If the aide is an individual with good character and at least adequate personal attainment, he is a beneficent influence in the ward. He is the "normal contact" for the patient. He is the guidepost,

the "average," the example. In order that the gap between the tormenting isolation of mental illness and the (hopefully) anxiety-free return to social living be bridged, the aide must be that cohesive force and arbitrator that resolves differences and makes social reintegration attractive.

The psychiatric aide is *an individual with specialized experience*. The countless events in the daily lives of patients constitute a set of ever-renewed emergencies. The capacity to meet such emergencies is partly based on the natural endowment of the aide. To a large extent he must exercise a quality of human judgment which renders him a potent force toward the emotional well-being of patients. The integration of his multitude of experiences into his own personal growth develops in the psychiatric aide a technically skilled person especially prepared to meet, deftly and judiciously, patients' urgent problems.

The psychiatric aide is *an indispensable gear in the machinery of a mental health program*. The final implementation of therapeutic systems and the application in great detail of the countless important little elements of living are in the hands of the aide who is in direct contact with patients. An entire therapeutic program can be almost meaningless without the aide through whom interpretations are mediated. He contributes to the comfort of patients, notes the effects of the different therapies, translates into understandable daily experience the therapeutic intentions of the institution, and serves as the connecting link between the patient on the one hand and the planners on the other.

The psychiatric aide must be *a person of considerable courage*. To come into the wards of a mental institution carrying with oneself the preconceptions and prejudices of the community and to consciously stifle the anxieties and fears that they generate in order to accomplish assigned tasks require an intrepidity which is often heroic although unpublicized. Operating in an area of no little hazard and encountering unforeseen emergencies at every turn, the aide's capacity to keep his wits about him, to protect himself, and yet to bring service and comfort to the very individuals who at times personally threaten him require a cool fortitude not unlike the bravery so readily extolled in soldiers.

The psychiatric aide is *an individual capable of personal*

devotion. In order that his services have meaning, that they be purposeful, that they be continuous, and that they be consistent, he must be devoted not only to the welfare of his patients and to the staff of professional persons whose therapeutic program he implements, but in addition he must be devoted to the lofty principles of group life in his community, to the administrative body at the helm of the institution for whose protocol he is emissary, and to himself. He must be capable both of self-scrutiny and self-esteem. His dedication to purpose requires an acceptance of many of the best spiritual values that mankind has developed.

The psychiatric aide must possess *an understanding of human emotional needs.* He is more than an employee, more than a participant, more than an observer—he must also be a student of human psychology. In many ways he may be described as something of an “intuitive psychiatrist” and “informal psychotherapist.” He must meet needs with appropriate supplies. It is his responsibility to comprehend the language of the emotional requirements of man and not just to respond to their expression through reaction and counter-response. He is a practical psychologist who should be able not only to define the needs of his patients but also to develop insight into his own emotional structure.

The psychiatric aide is *an individual who has the ability to participate as an integral part of a team.* Although autonomy of purpose may from time to time number among his prerogatives in the ward setting, more often he is called upon to extend services and functions already begun by others and then to pass on partially completed responsibilities to yet others. He must be able to gain satisfaction from the oft-repeated experiences of being a mere unit in a continuum of therapeutic forces.

A psychiatric aide in his best realization is *a person who promotes, elevates, and advances human welfare.* He is an instrument of culture, its servant and, where possible, its leader. Accepting the challenge of working with, living with, and feeling with some of the most tormented persons of our time, he assumes a considerable responsibility in creating out of himself an instrument for goodness.

Taken together we thus see that in his best representation the psychiatric aide is a member of the community having

specialized experience, who is an indispensable gear in the machinery of mental health programs, and whose courage and devotion, whose understanding of human emotional needs, and whose ability to participate in team operations render him an individual who promotes, elevates, and advances the cause of human welfare.

That this cause be well served, progress in the development of technical skills and in the improvement of standards of treatment is to be found not only in man's ideals, but, more important, such progress is to be found lived out and exemplified in the daily lives of such men and women as we recognize today.

Today mental illness, the nation's number one health problem, is at last receiving deserved attention. The professional personnel and intensively educated persons in the various services of this field are receiving plaudits, accolades, and interest from the community. In the background, somewhat obscured by the star performers, have been the supporting personnel who are the sum and substance of the time-consuming and arduous activities of total therapeutic programs. These are the psychiatric aides who have too infrequently shared the limelight. These are the silent partners in mental health.

THE MENTAL HEALTH OF THE ARTIST AS AN EDUCATOR IN THE COMMUNITY

MURIEL FOSTER, *Painter*

TO many people the idea of mental health for the artist becomes dispersed in an inevitable assumption that artists are necessarily a neurotic, disorganized bunch whose emotions and drives must remain entirely egocentric and anti-social. Perhaps this does make sense to the non-professionally-creative person. Nevertheless the artist himself has begun to search for the means to understand and orientate himself even in his "neurosis." (This he accepts objectively as a neurosis that he can do something about, according to the data accumulated by the writer in a research project studying 18 professional painter-teachers who were chosen at random. Of these, six had had psychotherapy and all were thoroughly familiar with current psychological and psychoanalytic schools.)

To these vital creative people, mental health for the artist signifies keeping afloat as an integrated personality in a world ordinarily hostile to this particularly productive kind of labor. To the same few, it follows that the artist must first of all consider himself a working member of a community. (We are not discussing here the artist who is more promotional businessman than artist.) And he must take the initiative in this practice even though he may feel unwanted and unappreciated.

Conditions for the artist in this respect, as a component of society, have, of course, varied in previous eras. His rôle until the nineteenth century was as a respected craftsman of plebian, *a priori* value to the projects of community and culture. At the same time, he painted, composed, or wrote what the patron dictated, be the patron church, prince, or merchant. Despite those restrictions, however, he had considerable leeway in techniques and styles of expression so that a certain freedom existed. A madonna might still be the portrait of a favored friend, a king pictured with all the weakness of feature he might have, regardless of extravagant and flattering trappings. A saintly leg could be anatomically distorted and appear all the more spiritual. A poem might extol the vic-

torious conqueror and still become a masterpiece of characterization. A piece of music composed for an effete court celebration might set patterns to be utilized by a century of composers. So the artist could maintain individuality in combination with usefulness in the world about him.

With the nineteenth century, the repercussions of the industrial revolution drove a wedge between the artist and his community. He was needed less and less in a world bent on mechanical development and mass production for peoples who were to become entities to themselves outside the previous paternal guardianship of king and church. The artist then first developed himself totally into an individualistic being. Because this became sterile as an end in itself, he withdrew into his inner self for his ideas of expression.

As the artist turned towards this kind of liberation of his own personality, his own representation of his reactions to the world, he sacrificed his direct contact with the activity of his community or, at the same time, appointment by the people as spokesman of that community. The reaction of the community is understandable in this sense. It could not be expected to probe willingly either above or below the artist's consciousness.

And so the artist's work was accepted only after ground had been broken for reception either superficially on the commercial level of the community, or after a few trained minds had made a clearly assimilated interpretation of it. This procedure required (and still does) the understanding of many complicated psychological processes. For example, it became necessary for any interested observer to overlook the indignity to his ego of not being adequately equipped or capable of comprehending the creative work of his time. This caused a conflict in his reaction to the problem that persists today: an envy of the artist for the freedom of his position, living a little aside from the main current of behavior, coupled with the resentment of the inability of understanding something that society, at least by lip service, considers important. The artist, on the other hand, resented his lack of contact with his fellow men in spiritual and economic ways at the same time that he recognized the development of his rôle as valuable soothsayer and spokesman for his own time even if not *in* his own time. Notwithstanding the political, social, and economic

structure of society (in which art is often given a superficial commercial value), there is much that might be accomplished by the artist to clarify and solidify his position. He realizes more and more that nothing concrete or beneficial can come from complete damnation of the kind of unappreciative world he feels he lives in. He realizes that if his society cannot get along with him, he must get along with it, not by stepping down from his highest aesthetic standards, but by meeting the daily life of his world head-on, with understanding of its effects on his physical and mental being.

He may be accused of anarchic indifference at the same time that he is being diagnosed as the most responsive of personalities. Such a paradox is hard for even him to balance. Perhaps he and his community need to reevaluate his need for spiritual and physical independence and withdrawal in their proper perspective as important, but matter-of-fact, components of his work. The arts are a matter of reciprocity between the artist and the public. Every writer wants to be read, every composer to be heard.

Is all this of particular importance to the non-artist, the majority of citizens, who can claim to be more concerned with what is felt to be the serious business of living? It is important for three reasons.

Just because he is so preoccupied with the *business* of living, the average man seldom has the sensitivity or can take the time to probe beneath the surface of life to find its real meanings and directions. This the artist can do for him. Secondly, the average man needs and wants to release his imagination and creative capacity in every metier, because he gets more in personal satisfaction and even material gain by this. (The personality characteristics of the successful business tycoon are similar in many ways to those of the less materialistic artist.) The processes of the artist in the expression of himself, and consequent definition in his work, are a pathfinder for others. At the same time and since, as Hughes Mearns said, "the general approval in our society goes to imitators," society's understanding of the creative person and that person's understanding of himself can help raise the general standard.

Finally, the more the artist comprehends himself, the better able he is to clarify and live with a belief which he of anyone

best expresses: the belief of man in himself, not as a rare, exquisite creature, but as an ordinary constituent of humanity. This should take place without either the crutches of a corrupt temporal and ecclesiastic society as was the milieu of Renaissance humanism, nor the overemphasis of physical science in which this society has placed its hopes and fears.

Mental health for the artist in terms of growth toward personality and career is seldom a conscious thing, except for the few classes for exceptional children in our large cities. The teachers here try to encourage the growth of gifted children, which may be valuable in placing a future writer, painter, or composer on the vague, proper track. But it is only among a rare, limited number of families that a gifted child may be encouraged with perspicacity in the home. Many potential artists, if not geniuses, have, on the surface at least, undistinguished and unprecocious childhoods. Moreover, most children are freely creative in imagination until late childhood.

Improvement here could only rest on a heightened awareness for parents and teachers of the need to continually encourage the childish free play of expression, with more stress placed on sensitivity from the child's point of view, *i.e.*, sensitivity arising from a conflict between his very introverted, self-centered reaction to events and feelings, and the matter-of-fact, critical observance of his behavior by his peers.

It is the writer's opinion, however, that the foregoing familiar and generally conclusive summation of the creative climate of the child might be enlarged. In our culture, which already has a Freudian heritage, we have learned that the development of a child before puberty is often a question of the curtailment of his natural egoistic desires for the necessity of adjusting to the life he will live with others, whose own wants he will have to consider. But we also have a tendency to urge a certain general standard of conformity on all children, regardless of their own adjustments to the world or their personal needs. We are guilty of this at all age levels, but with less knowledge perhaps of the results with children, and especially gifted children. We overlook the fact that the gifted child is somewhat aware of his potentialities. This intuition may be vague, but the ambition to write, paint, or compose may be formulated by eight or nine. This kind of child already feels a little different from other children his

age. He may not have a mental picture of this, but he does feel it. (Nine artists in the writer's research said they were conscious of this as children, before adolescence—one as early as five years—in a manner ranging from actual decision to pursue an artistic career to indistinct but willful feelings of a special insight for that purpose.) It should be possible for families and teachers to lend a non-condescending affirmation to these yearnings in terms of a special future preparation, avoiding the strangulation-of-the-virtuoso technique that is the other extreme.

This can be done only if the neophyte is handled in a matter-of-fact way and unselfconsciously and concretely helped to summon more drive to carry his interest through puberty and early adolescence with its shocks of crude reality that can completely choke off the free creative expressiveness of the child. The problem is, of course, one of keeping the spontaneity of the child and, in addition, the discipline of order. Too often, because of adult suspicion of the creative personality, this is an attempt at moderation. And moderation can become a washed-out compromise foretelling a personality that can participate only at half strength, with great anxiety.

Perhaps balance is needed here, balance as a middle between two extremes—those obvious extremes of either giving the child his head in all-out self-determination, or complete restraint and lack of confidence in his course of action in choice of careers and techniques. Either of these extremes has always been explosive, as the denial of one forces a dynamic against the only other outlet, which leads to the imbalance and distortion of personality of which many artists have been victims. It has never been proved that the sensitivity and insight of creative people are not primary forces of creativity rather than the traditional neurotic conflicts (which are more often useful to an artist in pushing him through all the barriers that surround his kind of career). But we place little value on sensitivity and insight, particularly in children beyond the kindergarten age. Then they must get "tough" enough to meet competition. (The artists interviewed in the writer's research project considered themselves tougher in their sensitivity than other people, because they were able to conduct their activity in the world outside themselves with more objectivity—to see behavior and mores so clearly that

they could choose outside behavior of their own at will with much humor and often some contempt for rigid modes of manner.)

One of the main problems to be treated in helping the adolescent artist is his conscious unwillingness to expose to anyone else his real feelings, which most certainly will appear in any serious creative work, and at this period with powerful intensity. This combined with his need to learn techniques, to say what he wants in terms of the real world, can often reduce his work to imitative levels. To the knowledge of this writer, this question has never been handled by discussing the subject matter of his art (as a whole) directly with the student, reassuring him about the validity of his emotional reaction to the world, rather than just the validity of free expression *per se*. This would, of course, require an uncommon amount of tact and rapport and confidence.

Paralleling this, an understanding of the artist's position in regard to the conventional rules of life might be interpolated. Sheer rebellion against conformity is not the intelligent procedure. (It is the writer's experience that there are three kinds of students in an art class for children and adolescents: those who want to please the teacher every step of the way and who may become artists by dint of application for this approval; those who completely rebel against all suggestion and method, who will become artists if they do not get too far out of adjustment; and those who are too immediately concerned with the manner of behavior of the average child of the group. They will not be able to become artists.)

The rules must be understood and used individually, constructively. The student has to understand that reality is different for everyone; so it is quite right for everyone to interpret the rules differently. His rules also must be organized so that he can eventually achieve some control over the problems of living that he has to face (to accept the economic necessity of a job, at least at the beginning, and to control his energy for his own work, for example). He needs to start understanding the importance of discipline. Discipline is not used here in its definition as the basic professional school function of training the student to get to his easel or typewriter to work by sheer repetitive habit, but rather as meaningful work by choice and free will.

The adult artist, for the purposes of this article, is the artist who has developed his work to the point of painting or writing independently, with some foundation of his own style as evidence of his own personality in his expressive form. His biggest problem is one of energy, whether or not he has to work at some money-raising job such as copywriting, teaching, selling, etc.

This man or woman needs to muster his forces consciously to devise a form of routine for working: to highly organize his life so that his own work can assume control at its proper time, enabling him to relax in it and follow its moods and intuitive directions. This sounds quite simple and obvious, but many artists waste years of trial and error in determining the best time of day, the best discipline, the best physical environment, most fruitful, stimulating recreations, simply because at the onset of mature work no analysis of these problems was undertaken or even given a meaningful significance.

Most of all, again, the artist must clarify his values for himself. He may want all kinds of experience, but he must find a means of selectivity for himself. He must understand that his values, rightfully, are a little different from those around him and keep his choice alive. He has to realize that emotional growth is valuable. When it is said that "there is a child in every artist," he must know that this refers to freshness of vision and spontaneity of expression, not arrested emotional development and childishness. He can learn, again, that reality is good for him, his ego functioning as a meeting force between his objective and subjective attitudes. It is only this merging of the two that will give his work through his personality any validity.

How can he become aware of this? Proper guidance in his art schools and colleges should be as available to him as to engineers or business executives, who may, at first glance, be associated with more prosaic professions in terms of concreteness of theory and practice. In amplification of proper guidance, here it may be suggested that the artist-student might consult with a guidance counselor in reference to the type of work he intends to do. If it is to be fine arts, writing or composing, the best way he may use in supporting himself in a secondary job (part-time, perhaps) might be pointed out, and various ways of alternating his schedule for the most con-

centrated work. But more importantly, the student might through the help of another trained person gain more insight into his own special problems of style, technique, and the creative process in relation to his own personality, and with this more indication of rapport with his chosen group.

How would this be fruitful to the community? It would serve to reflect the capabilities of the artist more directly for benefit to the community and help raise its cultural values. Where the artist is better equipped to meet and understand his society and his place in it, he can the more intensely reach it as a valid member of it. (This is not meant to imply a vulgarization of what the artist has to say—this he must always do on his own terms or he does not create art.) He certainly needs to interact with his society in a more positive fashion than by willing it an inheritance of his work.

One of the elements of his creative personality is the lack of division between his work and what he is. The artist wears a mask more thin than others, because he is himself. He has chosen what he does as a labor of love. There is no schizophrenia between himself and his job if he has matured professionally. This goes beyond the mere joy of doing the work and includes a psychology that can be useful to people concerned with other occupations or more humdrum tasks. The artist tries to do his job well to satisfy himself according to his *own* standards. This is not to say that he cannot apply a material value to his work, on the other hand. So the average person who is selling his services for money in a job need not always feel that he should keep his personal interest in functioning well out of it. (The artist applies himself just as thoroughly on work other than his own, because he sets his own standards of quality, and also because he is interested in learning more about living in any milieu.)

The artist draws an analogy between what he thinks and what he does. Perhaps this may be educatively possible for others. This may go against the main current of conformism; however, a little more conformism in our society may wipe out the vitality that individualism of our kind has created. The artist is sensitive to his surroundings and consequently usually tries to make them more pleasant, at the same time making his work more pleasant, an attitude that is daily becoming more respectable in the business world.

The artist lives intensely but does not develop high blood pressure more often than anyone else. He can say that he has experienced life even if he lives for twenty years in a four-block city area or an isolated village. Therefore he always feels alive, even to drudgery. And because what he does he does of himself constructively, he is not continually either burying or wasting his psychic energy. Many amateurs in the arts have begun to realize this: that approaching work creatively is a constructive release for emotions.

In every creative work there is a step-by-step development of material from the first insight of an idea, conceived in imagination, through the final touches of it. It may be true that the flash of illumination that darts in to start a painter on a picture or a composer on a symphony can only arrive after the artist has completely digested and understood his material, knowing it well. Memory has been thought to be the settling, mellowing factor from which the artist must produce. The writer, however, believes that time has very little to do with this. Rather, it is understanding, knowing thoroughly, that equips the mind with the means to say anything about an imagined idea. Because emotion is added to memory, so does the idea express itself differently in any person. (The investigation with artist-teachers revealed that nine of the subjects thought that emotional experiences affected their work immediately, whereas seven others, all out of a total of eighteen, thought that this occurred part of the time.)

Another phase of creative activity is the urge to work which an artist may get because of an emotional disequilibrium. He feels unfulfilled so he sits down to express himself, letting out his discomfort. Other people repress this or see a movie or TV show instead, but with, perhaps, the same emptiness continuing afterwards.

The artist identifies himself with life and nature. He reads himself into other people and life situations. This human capability is forgotten by those who do not find an outlet for their energies. An empathic individual is not an enemy to society, but do we teach this as a method? We say, consider your neighbor as yourself or live and let live, which are platitudes on a highly ideal level. Cannot we show young people the empathic process going on between all persons

without glossing over a very normal projection with allusions to morality? Understanding this objectively and its application might help prevent such quantitative manifestation of the strictly self-seeking person. In the teaching situation, and particularly in painting or writing, the empathic rapport *must* exist, for so much of what must be learned depends on the personalities in the class. In this connection several interesting answers were obtained in research. Of the artist-teachers interviewed 75 per cent thought that their students "felt themselves into" or were aware of their teacher's problems. Of the same group, 87 per cent believed that those students who were most sensitive to the wants and needs of others also had a better grasp of form in their painting.

The artist can also be a useful teacher in spotting outgrown habits of thinking that keep an individual from expanding and developing. In the same manner, the artist fights a society that tries to separate thinking and feeling. Often this fight is bungled, and so we see the full-blown bohemian who has some of the rebellion but none of the depth for real creative work. A respect for people who fight for more understanding and beauty for life can only be taught today, just as independence of spirit will have to be learned again by those who envy it in the artist but who are too ridden by fear to believe it in themselves. Yet without it many of them are breaking down. And this same independence of spirit is part of the emotional independence contained in the emotional maturity that everyone would like to reach.

Change is difficult for most people to comprehend just as it will be perhaps increasingly difficult for those who were born before the 1920's to realize all the implications of the atomic age in the coming generation. There has also been a change in the artist that has really been his first attempt to adjust to the upheaval of events as remote in time as the industrial revolution. The artist has stopped screaming about his uselessness, and has started to demand his rightful place. He asks that the rest of the people move enough to give him standing-room—not as they would break away for a crumble, in uncomprehending pity, but as they would casually make way for a man carrying a large bundle.

The artist is learning how he can work as a complete entity instead of believing in a myth of omnipotent discontent. He

fighters for the right of intuitiveness, however, even though he feels that he can know people more thoroughly with an understanding of such scientific aids as psychology and coordinated teaching methods. He recognizes that his expression of imagination is essentially a communicative one, unlike the fantasy of day-dreaming, for example. He and his fellow men can begin to see by means of education that creative thinking can be habitual, because emotions can be trained to react according to the habitual plan of the mind, the eyes, and the ears, if people are made aware of the simple, forgotten fact that this might be done intentionally as specific subject of learning, as well as further exploration psychologically.

Reams have been written on both the creative process and the importance of the artist on the historic-social scale. Can we not apply some of this knowledge directly for use in the society? We have already done this to a certain extent for our scientists. Why not for the painter, writer, sculptor, or composer?

THE CHILD IN THE HOSPITAL *

In 1951 the WHO Regional Office for Europe as a part of its long-term activities in child health initiated plans for a meeting between pediatricians and child psychiatrists at which they could discuss their respective rôles and the coördination of their work.

Early in 1953 an ad hoc committee was called together to discuss the possibility of holding a conference which would delineate the rôle of the pediatrician in the management of psychosomatic and behavior disorders in young children. This committee, consisting of leading specialists in pediatrics and child psychiatry, under the chairmanship of Professor R. Debré (France), felt that any wider conference should be devoted to considering more fully the interrelation of somatic and psychological processes in sick children, the respective rôles of pediatricians and child psychiatrists in their treatment, and the working relations between the different disciplines responsible for the care of children.

In order to avoid diffusion of effort, and to arrive as far as possible at practical conclusions, the study group that was subsequently convened in Stockholm concentrated on one important aspect of child care — the child in the hospital.

* Account of the meeting of a study group, sponsored by the Regional Office for Europe of the World Health Organization in coöperation with the Royal Medical Board of the Government of Sweden and the Department of Pediatrics, Karolinska Hospital, Stockholm, held at Stockholm on September 2-11, 1954.

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Copies of a French translation of this account may be obtained on request to the WHO Regional Office for Europe, Palais des Nations, Geneva, Switzerland.

There is a list of participants at the end of this article.

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INTRODUCTION

THERE is a growing realization of the need to consider the child as an entity and to bring into play all the resources for the protection of his mental as well as his physical health. Yet the degree of coördination and team work between pediatricians, child psychiatrists, and other specialized workers concerned in this field still varies tremendously. In some countries psychiatric services have scarcely developed, while in others the available child psychiatrists play a limited rôle, if any, in the pediatric services.

The primary purpose of the meeting in Stockholm was to bring together in Europe representatives of the principal disciplines responsible for the care of children in the hospital. In the course of their study and through the exchange of their very considerable experience the specialists in the study group arrived at certain broad conclusions which may serve to stimulate further interest in child care.

There was no fixed agenda, nor were there predetermined plans for conducting the discussion, except that it should keep within its agreed scope of the child in the hospital. Six case-histories were presented by pediatricians and child psychiatrists who normally work together, in Sweden, the United Kingdom, and the USA. These case-histories were chosen to illustrate the comprehensive care of the child in the hospital and problems of staff coöperation, and not for the purpose of discussing their clinical aspects. After the presentation of each case, discussion followed under the leadership of a chairman selected in rotation.

The study group included 20 pediatricians, 10 psychiatrists, a medical social worker, and a psychologist, from countries representing a wide variety of conditions. A Swedish nurse was also present during the discussion of one of the Swedish case-histories.

The entirely informal character of the meeting led to frank and spontaneous discussion with keen interest in understanding different points of view.

Although the group concentrated on the work carried out within the selected environment of the children's hospital, there was frequent allusion to the need for similar studies on relationships with the family doctor, the obstetrician, and the

personnel of child welfare centers. Among other related problems it was felt that hospital design required further study.

Much attention was focused on the urgent need for a new approach to training and for important changes in the curricula for physicians and nurses working with children. The extent of factual knowledge in many medical fields is one that the most highly gifted individual can barely encompass. Specialism is inevitable, but the continuous process of fragmentation of knowledge cannot continue without detriment to the individual and society unless there is a compensating synthesis in basic training and in practical team-work. This was emphasized time and again in the discussions.

There are certain fundamental aspects of knowledge about family life and child development and the effect of illness on the individual which are still almost entirely neglected.

Future emphasis must lie in learning and relearning the basic essentials, and in the fullest use of available specialists, not all necessarily medically trained but able to provide the additional information in their own field on which a successful synthesis in diagnosis and treatment may depend. It is not fragmented knowledge but a whole approach to the child in his present environment that is needed. And it is the children's physician and the family doctor who are best placed to discern what special skills are required, to coördinate their use, and to effect the synthesis.

This account can only inadequately reflect the general feeling and atmosphere of the meetings of the study group. The detailed discussions that occupied seven working days are necessarily given in summarized form, but their range and main trends are indicated, including suggestions as they arose, sometimes from individuals, sometimes from the group as a whole.

Three major topics emerged in the course of the discussions. The first concerns the total well-being of the child in the hospital in terms of his emotional and physical needs. This leads to the second consideration, the basic training required for work in this special field. The third topic is the coördination of services within the hospital.

Some general conclusions and many suggestions are described under each of the three main subjects in the hope that these may stimulate increasing interest and further study.

CHILDREN IN THE HOSPITAL

Few will dispute that the best place to care for a child is in his own home among familiar surroundings, where the people who normally give him security and affection can tend to his needs. The young child under five, in particular, is unable to understand what illness is. Even for an adult, who knows that the interlude will sooner or later come to an end, admission to a hospital is a major event. For the small child, who has no realization of time, the break is final and irrevocable unless he has some tangible means of grasping that this is not so.

Moreover, increasing knowledge of the child's emotional development has brought home to us once more that physical care does not necessarily go hand in hand with mental well-being. Experience clearly illustrates that admission to a hospital, particularly where the atmosphere is "institutional" and frigid, may lead to acute depression that can reduce the value of physical care and even contribute to a fatal outcome. It may also impair the child's mental outlook for the rest of his life.

It is necessary, however, to be realistic about the question of admission to a hospital. Two major issues have to be faced: on the one hand, the child's physical state must have the best consideration and treatment that medicine can give; on the other, his emotional needs are just as important and must be equally well cared for.

The study group not only considered criteria for admission and how best to minister to the child while under hospital care; it also realized that if he is indeed to be cared for as a human being, with thoughts and feelings as well as physical needs, he must be prepared to meet the change and stress consequent upon admission and later upon discharge and after-care.

The Problem of Admission

It sometimes happens that after frequent attendance as an out-patient a child makes little progress and is admitted to hospital because the pediatrician is at a loss what to do next. No pediatrician is practicing good medicine if he admits a child to a hospital for this reason alone. The physician must

be clear as to the reasons for recommending admission and what investigations he proposes to undertake. He may want to see his patient in the environment of a hospital, using the knowledge thus gained to advise the parents. Yet whatever the motives, whether they are primarily observational or primarily therapeutic, he should first be convinced of the unconditional necessity for this step.

Apart from cases where admission for investigation and treatment is essential or a matter of emergency, there are also other considerations arising from social conditions.

Many illnesses could be treated at home if the services and available care were more adequate. Two very real problems are raised in many cities by overcrowding in the home and by the fact that both father and mother are often out at work all day. Under such circumstances when a child falls ill the immediate reaction of the parents is to seek his admission to a hospital, where he is likely to be adequately cared for. There is no doubt that pediatricians are often forced to accept this situation and admit children when they would otherwise choose to avoid a separation from the home.

Such problems can only be met by social measures which, strictly speaking, fall outside the special province of this study. Nevertheless, as the factors mentioned often closely affect professional decisions on admission to a hospital, a valid social argument can be advanced for improving medical services and care within the home.

With this in mind it was suggested that:

- (a) a reserve staff might be established for enterprises employing women so that mothers could be released to care for their children when they fell sick, without losing their jobs;
- (b) a mother should be given a daily benefit equivalent or comparable to her wages to enable her to look after her child in such circumstances.

A Hospital Case from Background to After-Care

In order to illustrate a number of the problems raised by the admission of a child to a hospital some brief extracts are given from the case of Johnny, which was presented to the study group as a basis for discussion.

History and preparation for admission

Johnny, aged 2½, had suffered for 18 months from repeated upper respiratory infection with severe head colds and ear-ache. His speech was very unclear, his behavior restless, destructive, and demanding; he was suffering from broken sleep and frequently came into his parent's room at night.

He was the only child of a 23-year-old mother and a 27-year-old father, who was employed as a clerk. The mother went back to work as a full-time telephone operator when Johnny was six months old. Her schedule was irregular and Johnny's home life in the over-indulgent but quarrelsome atmosphere of his grandparents' flat had been chaotic. When he was two, however, his mother gave up her job and the family obtained a flat of their own.

Despite his background, he was a contented child until he went to the hospital at 20 months of age to have a lipoma removed from his right arm. He was an in-patient for three days and visiting by the parents was not allowed. When he returned home he was found to be tense and irritable and unable to settle to any activity for more than a moment or two.

When, in the present instance, he attended the hospital, the clinical examination was difficult because of his irritability and restlessness, but he was found to be physically normal except for his unhealthy tonsils and adenoids. He was given symptomatic therapy and seen again three days later.

After careful consideration, tonsillectomy and adenoidectomy were advised and his mother was asked if she would come into the hospital and be with him all the time. This she agreed to do, though with some apprehension. A week before admission he attended the hospital again, this time in order to be told in his own language what was going to be done to him, and to be shown where he would stay.

It was explained to his mother how she should talk to him about the operation on the two days prior to his admission, and she discussed with the medical social worker certain anxieties she herself retained in connection with operations she had undergone. The boy played with a nurse during this interview.

As this child had fears about defecation and was as yet not toilet-trained, the nursing staff were asked to avoid all manipulations round the anus such as would be involved in rectal temperatures, enemas, or anesthesia. They were also asked to help the mother to take an active rôle when she was in the ward and to encourage her to speak freely about her own anxieties and to ask questions.

Admission

Johnny settled down to play happily in the playroom with the other children and slept well the first night. The following day the nurse, whom he knew, gave him his preoperative injection and took him to the operating theatre, as he had been told would happen. Unfortunately, he was still awake when he reached the theatre and he struggled for a few moments while going under the anesthetic.

His mother was present as he came round from the operation, which was uneventful, and was able to reassure him as he awoke from time to time. The following morning it was with reluctance that he left the playroom in order to return home.

After discharge

Three days later he attended the hospital for the routine throat examination and was encouraged to play with the toys and water. He showed no fear on returning and seemed to have suffered no ill effects.

A developmental examination, given in due course, showed that he had made more than 12 months' progress since his first examination nine months before, and a nursery school was recommended. He had in the meantime become very coöperative about his toilet training. A key factor in improving the mother's relationship with the child had been the hospital experience, during which she had learned to handle him more consistently and understandingly. As his health improved she grew proud of his progress and was able to show him increasing affection and approval.

Planning for Admission

Johnny illustrates a not uncommon history of traumatic experiences due to unhappy separations from home or earlier hospitalization to which the child has reacted badly; it is most important that the full background in such cases be brought to light.

In other cases, though less time and effort may be involved, admissions should always be carefully planned by the pediatric service in the light of knowledge of the home background and of what the hospitalization is attempting to achieve. So far as possible, account should also be taken of the child's age and understanding.

Unfortunately, our knowledge of what the young child understands and perceives at each age level in terms of the body image is not yet complete. What we do know is that without some explanation and adequate precautions he easily resorts to troubled fantasies. This particularly applies to children in the pre-school and infancy periods. They frequently feel what is happening to them to be a rejection on the part of their parents or a punishment for some way in which they have behaved, and unspoken fears may remain with them for the rest of life.

Careful precautions should be taken in the timing of the admission. For example, the pediatrician should, where possible, avoid sending a child into a hospital just before or after the birth of another baby in the family, especially if the child in question is too young to understand why he is going there.

There are also ways of helping children in a general manner. In one country, a booklet is in use giving advice to parents on

the way to prepare their children for admission, and this has proved of value. This idea might be further developed by inviting an artist skilled in illustrating children's books to produce a suitable publication after making himself familiar with the hospital atmosphere.

Emergency cases present a different problem. Various circumstances may necessitate sudden admission, at times matters of life and death, where the physical aspects have to be dealt with first and foremost. The situation is usually one of anxiety. The parents need help and support, and should be allowed to stay near the child and be with him when he regains consciousness. Should they be over-excited and have a disturbing effect on the patient they may be allowed to stay on the premises but should not have intimate contact with the child. In such cases, the medical social worker can play a valuable rôle.

The psychological problems that arise in instances of this kind are best resolved by letting the child subsequently "play out" his experiences in the hospital playroom, where he is under observation and has the help of the play nurses. This "abreactive" activity should be encouraged when he is in his own home again.

Admission of the Mother with the Child

In spite of the fact that the mother herself had some anxieties about being in a hospital, it was decided in the case of Johnny that it would be traumatic to him if he were left alone without her after his earlier experience. There is no doubt that her admission proved valuable in allaying anxieties in the patient and in educating her as a mother.

When should arrangements be made for the mother to come into the hospital with her child and when is it inadvisable? There are often other young members of the family who need the mother's care. The father should not be forgotten either, and in the interests of good family relations, if his wife is to accompany the child, he must have a proper understanding of the need for this step.

If these difficulties can be satisfactorily overcome, should the mother be admitted with the young child in all cases?

In this connection attention was drawn to the outstandingly good results which had been obtained by the Pickerills in New

Zealand¹ in a hospital for the surgical treatment of infants where every child is accompanied by his own mother, and lives and is cared for entirely by her except when he is in the operating theatre.

On the other hand, it may be asked if there is not a tendency, in avoiding all trauma, to make the child's life too easy. There will be general agreement that life cannot be lived without experiencing difficulties and the struggle to overcome them. But with small children the "dosage" of stress must be graded, as the level of tolerance is low. Certainly, children must meet tension-producing experiences, but they need to be helped to develop a gradual sensitivity to some situations and the necessary insensitivity to others at the optimum pace. Some parents are in the habit of "toughening" their children from birth because, they say, "life is tough and real." There are pediatricians, too, who "streamline" infant feeding to the point of giving infants three meals a day at the age of six weeks whether they need it or want it. When children are upset by hospitalization it is not uncommon to hear it said: "As long as there are child psychiatrists and child guidance clinics to take care of the casualties, let's not worry about the rest."

The need for prevention in the psychiatric field may not only tend in this way to be minimized as a matter of policy; it may be neglected under the sheer pressure of clinical activities.

In the light of these considerations the study group wished to emphasize the value of the mother's admission as a prophylactic measure. It has been a frequent practice for many years with private patients, and has undoubtedly proved its value. When the pediatrician and psychiatrist feel it is of major importance, children should have their mothers with them throughout their stay in hospital. In certain other cases, the mothers should at least spend the early period of the admission with the children to help them to settle in.

Technique of Reception

In all cases, whether the parent stays in the hospital or not, the "technique of reception," which calls for an imaginative

¹ Pickerill, C. & Pickerill, H. P. (1954) The elimination of hospital cross-infection in children: nursing by the mother. *Lancet* 1, 425; *Lancet* 1954, 1, 447 (Editorial: The mother as nurse). Further reference is made to the work of the Pickerills later in this account.

appreciation of the child's feelings, should be made a subject of careful study.

At this stage it can be said that he should not be deprived of the toy from home with its familiar smell or be divested of his own clothes, nor should a bath be forced on an unwilling and anxious child. The ward he enters should be a small one, with furnishings he will appreciate, and his bed or cot should be in keeping with what he is used to at home. These small and apparently trivial details are important ones for any child.

The staff, in helping him over the separation from his parents, should avoid obvious deceptions, for above all the child needs to feel confidence in those who are going to care for him.

Hospital Design

These considerations raise a further important problem — that of hospital design. Hospitals in the past have generally not been constructed in such a way as to promote the homey atmosphere that is desirable, though in many cases much can be and has been done to modify internal arrangements. Modern hospital planning and construction, on the other hand, at times shows a tendency to other faults. In particular, there is the hospital of ultra-modern design, with the last word in technical equipment, where, in contrast to the large old-fashioned general ward, each child is in a separate glass-walled compartment conveying the impression of a refrigerator.

There is a strong case for more extensive examination by doctors and architects of the problem of hospital design for the future; consideration should be given to the provision in children's departments of small wards or rooms capable of reproducing home conditions and with accommodation for accompanying mothers. In a number of cases a satisfactory arrangement has been provided by separate cottages or "pavilions."

Hospital Procedures

In the case of Johnny, care was taken to avoid any routine procedure that might be harmful to the patient. From the discussion it was clear that routine procedures, though often not essential, continue in many in-patient and out-patient departments. The highly-skilled and sensitive physician is

alive to the need to dispense with many routine activities, requests for unnecessary investigations, the use of old-fashioned and clumsy apparatus such as heavy syringes, and pre-operative enemas. These and many more procedures should be given careful consideration in the light of what they mean to the child. In this connection, too, the child should not reach the anesthetic room in a state of frightened awareness.

Even more important is the creation of the right emotional atmosphere in the ward. Here, two main contributing factors received especial attention: day-to-day care of the infant or child in terms of his relationship with the staff, and the maintenance of home contacts.

Relationship Between Child, Nurse, and Doctor

Divorced from his home surroundings the child needs to acquire some familiar support which will give him a sense of security. This is often denied him when he is faced with a succession of different nurses at his bedside.

One instance was given of a West African nurse, whose success in a children's hospital was attributable in part to the ease with which babies could identify her in a sea of other faces. Normally, the familiar face, the intimate touch and especially the sense of security, can only be provided when each child is assigned to one particular nurse to whom he becomes accustomed throughout his illness. Despite the shortage of nurses every effort should be made to insure that this is done. This also applies to the doctor. Having once started to form a contact with the child in the out-patient department he should, whenever possible, follow through the treatment to the final stages.

Visiting and Family Contacts

The Visiting Mother in a Case of Feeding Difficulty.—The following case is presented very briefly to indicate how a mother's visiting was planned to fit in with the therapy.

Sammy was a 13-months-old boy living in a socially and economically deprived home, who was admitted to the hospital because he had refused solid foods from the age of 6½ months. This fear of solid food had produced a severe iron-deficiency anemia, a retardation of development, and increasing weakness. Despite efforts on the part of a social welfare agency to help the mother, no change for the better took place.

The food refusal was diagnosed as the manifestation of a disturbance in the mother-child relationship. Hospitalization was advised in order to provide a favorable environment in which the mother might establish a good relationship with her child, and to investigate and treat his anemia.

The nursing staff were given full information about the child and were specifically asked to let the mother feed him when she visited him twice daily. He was given a blood transfusion and iron therapy, and his response to the attention and help began to show clearly by the third day when, for the first time, he began to eat solids and to play with toys in his cot. He welcomed his mother with obvious pleasure and was unhappy when she left, but he subsequently became happy and smiling with the members of the staff who cared for him.

From the ninth day he sat up easily and ate everything that was offered him. On the fifteenth day he went home to his mother. His progress was then followed by the medical social worker and the public health nurse who maintained contact with him and helped the mother to get toys, a playpen, and a high chair, also advising her over various points she raised. He was seen regularly at the well-baby clinic and proceeded to make rapid strides in his development.

The salient point in this case is that while physical treatment in the hospital would probably have afforded Sammy symptomatic relief in any case, it was only through the mother's education and change in attitude within the hospital environment that the vicious circle in her relationship with the boy was broken. Thus, he could be sent home without fear of a recrudescence of the conditions that gave rise to his complaint.

Some Different Approaches to Visiting.—In this case the full significance of visiting is abundantly clear. But in other cases, where the relation between it and therapy is not so evident, visiting still plays a most important rôle.

It is interesting to note that in Italy, a country traditionally warm-hearted in its attitude to children, visiting has never been forbidden except in individual cases where it has been considered to be to the serious detriment of the child.

An interesting contrast to the particular western trend of "toughening" the young child was cited from the customs of another culture. While working in East Africa, one of the study group had noted that when a child was admitted to the hospital he was never alone during his whole stay there. His mother or some member of his family was always by his bedside day and night, sometimes, indeed, the whole family. One of the difficulties was to prevent the mother from removing the child from bed during the night to sleep with her on the

floor or, if she was told this was not the best thing to do, she would then want to get into bed with the child. This had given him food for thought, for there appeared to be less evidence among these children of psychological disturbance. He later worked in close contact with Dr. J. Bowlby, on the steering committee at the Tavistock Clinic, which was engaged in studying problems arising from the separation of mother and child in early life. He had come to the conclusion that he must change the existing rules in his ward and with the collaboration of the head nurse it was decided to permit daily visiting in selected cases. The results proved so successful that head nurses in other wards asked for it as well.

There is a tendency, probably due to the exaggerated attitude of the lay press, for mothers of young children who have undergone hospitalization to blame all behavior difficulties on this experience. Parents, however, often have a right to complain that family contact with the child is not given its due consideration. The first hospitalization in the case of Johnny illustrates the possible ill-effects of denying visits. There are still children's hospitals in a number of countries where visiting is forbidden and many others where it is grudgingly permitted once weekly, or even less, while little understanding is shown of all the emotional implications which are involved.

Visiting and Infection.—One of the arguments against visiting has in the past been the risk of infection brought in from outside. When wards were big there were few facilities for isolation, and deep concern was felt when a child admitted for one complaint contracted another illness and died in the hospital, an occurrence which was all too frequent 30 years ago. Since then a new situation has developed.

Thus, in the United Kingdom, when the rebuilding of hospitals was under consideration in 1945, the British Pediatric Association set up a small committee which studied factors that might affect their design.² Among these, the question of cross-infection was investigated and it was noted, from a careful statistical analysis of material collected in 12 different centers, that there was no positive evidence that visiting by adults in any way increased infection.

² Watkins, A. G. & Lewis Faning, E. (1949) Incidence of cross-infection in children's wards. *Brit. Med. J.* 2, 616.

The indications are that hospital infection is usually introduced by other children and the experience, already mentioned, of the Pickerills in New Zealand, where mothers are admitted with their children, supports this view. Moreover, pediatricians now have new drugs at their disposal for the control of infections. This makes it easier to turn to a fuller consideration of the child's emotional and mental requirements.

Technique of Visiting.—In order to introduce visiting effectively various factors need consideration. In large hospitals visiting hours have to be staggered to prevent congestion. In New Haven, Conn., for example, they are flexible — the mother and father being permitted to visit children not critically ill twice a day between stated times, while in critical cases arrangements are even more relaxed. There is no compulsion on mothers to visit, but they are encouraged to do so. In a number of hospitals experience has shown that both visiting hours and the regularity of visiting must be selective, bearing in mind the child's relationship with his family and the parental attitude.

The over-anxious, disturbing parent and the child with a very distressing illness often present visiting problems, and in some cases it may be advisable to apply restrictions. Nevertheless, a mother may insist that she has a right to see her child. The pediatrician should resist this attitude, for the child is under his care and it is he who must make the final decision in the interests of the well-being of his patient.

The handling of visitors is a question that deserves careful attention and if properly organized can bring valuable results. Mothers are found to fit into the life of the ward much more easily when given something to do; it is inadvisable for them to sit aimlessly at the child's bedside. They should be encouraged to play with the child, to give him his evening wash and his supper, to read a story, say his prayers with him, and tuck him up for the night. With luck the child will fall asleep before his mother has slipped away.

While for the younger, more vulnerable, ages contact with the mother is irreplaceable, older children often value visits from their friends of the same age, and such visits have been encouraged with good results.

The visitor who at times fits less easily into the hospital

surroundings is perhaps the father. This does not mean, however, that his visits can be neglected.

Finally, the fact must be faced that visits, however well organized, inevitably cause a temporary disturbance, not only in the hospital routine, but to the patient. It is often felt by the nursing staff that the brunt of this disturbance falls upon them, both during the visits and after, when the child most keenly misses his visitor. Many parents, too, have questions to ask which the nurse does not always feel she can answer. For these reasons parents should have easy access to the head of the department and a doctor should always be present whenever possible to give support during and for a short while after visiting hours.

Visiting in Long-Stay Cases.—The psychological difficulties which inevitably arise when children with chronic illnesses have to stay in a hospital for many months raise special visiting problems. To maintain a steady relationship with the family is difficult enough when the hospital is within easy reach of home; but when it is situated a long way off in specially chosen healthy surroundings its comparative inaccessibility makes the task well-nigh impossible. There is good reason to subject the value of long-stay special hospitals and convalescent homes to very careful review. There can be no doubt that the case of each child about to be sent away for long-term treatment should be thoroughly examined from every angle.

It is of interest that before admission to one school for children with cerebral palsy each family is visited by a psychiatric social worker, and full psychiatric examination is made of the child some time ahead. The best method of maintaining family relationships can thus be fully explored.

Many members of the study group felt that for visiting remote long-stay cases parents should not only be allowed travel allowances, but should be paid for their loss of time from work in order that the family contact might be maintained.

Where a special hospital is situated near a big city most of the children can be visited, but there may be one or two children in a ward whose parents live too far away to pay more than rare visits. The pediatrician must bear in mind that such children may become psychological casualties. Every attempt should be made to prevent this; where there are play nurses

these are invaluable, as they can devote extra attention to the lonely child. The good offices of local visitors can also, in part, alleviate the problem, though neither can fulfill the rôle played by the parents.

Preparing for Discharge

In the well-run pediatric hospital, with an understanding staff and good playrooms for the ambulant child, it may be found that the young patient is reluctant to go home. In general, this would not support an argument for more frequent and longer admissions, though it may, in individual cases, indicate that a child's home life lacks the facilities for friendship and play and the sense of security that he has unconsciously come to appreciate in the hospital.

The unfortunate effects of the less adequately run pediatric hospital have already been indicated, and in any case hospitalization may subjectively come to represent rejection by the parents.

Under these circumstances what methods should be employed to render the discharge smooth and uneventful?

The pediatrician will, of course, give his advice to the parents in the light of what he has learned of the home conditions from the family doctor or the social worker.

There is a growing practice now for pediatricians to see the parents not only individually, but in groups. It has been found of great value to invite the parents of children suffering from one disease, as, for example, diabetes, to come to the hospital together and discuss their anxieties freely with the pediatrician. The latter, in turn, explains to them frankly how they can best help their child after discharge.

If the child has been in the hospital for a long time, and his home is at a distance, it is helpful if the mother can spend a few days with him in or near the hospital prior to discharge. Another alternative is for him to go home, first for a day and then for week-ends, before his final return. This, especially in the case of an older child, makes for a smoother transition.

In these matters the medical social worker and the public health nurse have a very important part to play. They know the home situation and can help in the smooth reestablishment of good relations. If the child remains in an over-anxious state and is in dread of the hospital, it is these workers who

are best placed to discover and bring it to the attention of the pediatrician.

It need scarcely be emphasized that continued contact between the child and his parents throughout his stay in the hospital offers the best assurance of a smooth transition on discharge.

Conclusion

The main points that emerged in the course of discussion may be summarized as follows:

1. A child should be admitted to a hospital only when the pediatrician is fully convinced of the necessity for his step; the fact that admissions are sometimes made because the right conditions or care are lacking in the home points to the need for social measures to meet the situation.
2. Admissions, wherever possible, should be planned ahead and timed in the light of the child's age, his family circumstances and background, and in relation to the purpose to be achieved; in emergency cases, where this cannot be done, it is suggested that adequate provisions for play therapy within the hospital may considerably ease the effects of sudden admission. Published advice to parents on preparing children for admission can be helpful and meet a real need.
3. Provision should be made for the mother to be admitted and stay with her child where the pediatrician considers it necessary, and in other cases to settle the child in.
4. Every effort should be made in the future to provide hospital accommodation that will allow for the admission of mothers and for the reproduction, so far as possible, of homey surroundings familiar to the child.
5. Hospital procedures, painful or otherwise, that may have a traumatic effect on the child, should be strictly avoided unless absolutely essential.
6. It is strongly advisable, within the limits of staffing facilities, for the same doctor and the same nurse to follow through a case to the end, in order that the sense of security necessary to the child may be provided.

7. Visiting as a general rule is strongly to be encouraged, with the proviso that the pediatrician always holds the right of decision in individual cases; fathers and friends, as well as mothers, can be valuable visitors; the value of visits can be enhanced if helpful occupations are found for the visitors.
8. The value to children of long periods in hospitals and institutions remote from home is in many cases open to doubt, and great caution should be exercised before a child is thus sent away. Where it is unavoidable, special allowances might be provided to enable parents to visit regularly. Care must be taken to prevent the child who is without visitors from becoming a psychological casualty.
9. The child also needs preparation for discharge and, in long-stay cases, he may require gradual acclimatization to home contacts and surroundings.

TRAINING

To what extent should the pediatrician be a psychiatrist, or the psychiatrist a pediatrician, and how far should the nurse be familiar with the work of both? The extent and character of additional training that each should receive occupied an important place in the work of the study group.

The varied conditions obtaining in different areas make it impossible to arrive at conclusions that can apply in all circumstances. In many countries, few pediatricians, even fewer nurses, and no psychiatrists are available to care for the child in a hospital. Elsewhere, although there is more efficient control of physical disease, an increasing number of psychological problems have appeared among the child populations and fresh difficulties have to be faced in this field.

These problems can only be solved in the light of a country's own particular needs. The work of pediatric teams and the creativeness of specific local genius may well be impaired by rigid imitation of training methods used elsewhere. Nevertheless, there is much to be learned from an exchange of experience, and certain practices can be usefully put into general use, either in their original form or modified to suit a country's requirements.

The summary of the discussion given in the present section falls into three parts — the teaching of pediatrics, the training of the child psychiatrist, and the training of the pediatric nurse.

The Teaching of Pediatrics

In this first part, Dr. M. J. E. Senn, professor of pediatrics and psychiatry at Yale University, described the development of pediatric training in the U.S.A. and more particularly in the department under his direction. He prefaced his statement with the remark that, only a few years before, he himself had suffered from the same limitations and difficulties that faced many a pediatrician today in other parts of the world. And it still remained to be seen whether his experiment would succeed and whether a careful balance between the skills of physical medicine and the dynamic concepts of psychological medicine could in the end be evenly maintained.

The views of Dr. Senn and the description of the experimental methods in use at Yale over the past fifteen years are given in part below in his own words.

Historical background

The first practitioners of pediatrics were physicians who limited their general practice to children, sometimes combining obstetrics with child care. Their attention was focused on the diseases of childhood, but as the public health movement developed attention was paid increasingly to the prevention of illness and the promotion of health.

With the rise of scientific medicine and increased use of the laboratory for investigation and diagnosis, pediatrics assumed the status of a true speciality. At approximately the same time that scientific methods were being applied in the diagnosis and treatment of sick children, the behaviorist psychologist, Watson, was adapting Pavlov's work on the conditioned reflex to children, showing that they could be conditioned and unconditioned to the fear of animals. These studies influenced pediatrics momentarily in that they provided pediatrician and parent alike with new ideas on the rearing of children. Apart from psychologists, physicians, including some pediatricians, began in the early 1900's to show interest in neurological diseases and in the pathology of the brain.

No marked influences from psychiatry became evident until after the first World War, when, with the rise in juvenile delinquency, lay persons rather than physicians promoted the development of psychiatry and started the child guidance movement. However, even as recently as 1930, psychiatry was not integrated with the rest of medicine, and pediatricians saw nothing of value to them in medical psychology apart from intelligence testing. At about that time pediatricians were still teaching parents the tenets of behaviorism, although the parents themselves were beginning to

question and even resist any advice about child care which was rigid, artificial, or mechanical. As with the public health movement in the U.S.A., the impetus for the development of child psychiatry and general psychiatry came rather from lay persons than from medical groups, and two American foundations, the Rockefeller Foundation and the Commonwealth Fund, must be singled out as potent forces in this direction.

Not only was the Commonwealth Fund interested in establishing child guidance clinics and in training child psychiatrists, but by 1935 it was sponsoring training in psychiatry for certain pediatricians, to enable them to become pediatric educators and to explore the possibility of integrating psycho-dynamic principles into everyday pediatric practice. Although interest in broadening pediatrics was not general at that time, there were a number of pediatricians who were beginning to appreciate that, if it was to remain a special branch of medicine, pediatrics must concern itself with more than the physical diseases of children. They were faced with a mounting number of behavior problems about which they had little or no knowledge, and they lacked the skills necessary for their treatment. At the same time a decline in some of the problems arising from physical illness was evident. Infectious diseases were more easily controlled, complications prevented, and the nutritional disorders of infants and children more easily recognized and treated.

The problem of integrating psycho-dynamic principles with pediatric practice

The desire of pediatricians and psychiatrists to collaborate in training and to work with parents and children gave rise to a number of practical problems. Should sufficient child psychiatrists be trained to work as teachers, diagnosticians, and therapists in departments of pediatrics? Should pediatricians be given opportunities to learn from psychiatrists, but continue to practice only within their own field? Or should there be a new specialist called a "pediatric psychiatrist"—a hybrid physician, not quite a child psychiatrist, but with more training in psychiatry than a pediatrician usually receives?

Answers to these questions have not been fully resolved in the U.S.A., though attempts to experiment with each of these approaches have been made. It has been evident for a long time that there will never be enough child psychiatrists to deal therapeutically with the emotionally disturbed child and his parents. The first suggestion, therefore, seems impracticable now and for a long time to come. This means that the child psychiatrist will not be the sole person responsible in the psychological aspects of pediatrics.

Of the two remaining possibilities, the second has seemed a more natural development than the third, for it has frequently proved impossible to differentiate those designated "pediatric psychiatrists" from child psychiatrists. I believe that the well-trained pediatrician must be prepared to provide his patients with comprehensive medical care based on the treatment and prevention of physical disease. He must not only be skilled in the diagnosis and treatment of disease; he must also be alive to the psychological concomitants of physical illness and to methods of dealing with them. Thus, there should be no dichotomy of health and illness, of psyche and soma. Furthermore, he must be interested in the growth and development of healthy infants and children and have the insight and

skill to promote health and prevent illness. A pediatrician who deals comprehensively with his patients will, of necessity, be able to perceive the beginnings of emotional disturbances and, what is more important, will become an instrument in the community to prevent such disturbances.

From the foregoing it will be clear that I advocate the incorporation of many principles of psychological medicine into non-psychiatric disciplines. I believe, however, that the pediatrician should remain a pediatrician and practice within his normal field rather than set up a new branch of medicine called "pediatric psychiatry." This does not mean that I am uninterested in the further development of child psychiatry as an important special branch of medicine. For the purpose of this discussion, however, I would emphasize my feeling that the pediatrician today is particularly well placed when it comes to preventing emotional disturbances or dealing with them in their incipency.

The experiment at Yale

For the last 15 years I have concerned myself with pediatric education at the postgraduate and undergraduate levels, attempting to demonstrate natural and effective ways of educating non-psychiatric physicians in the principles of medical psychology, and to show that psychiatry offers various skills and approaches capable of sharpening pediatric insight and improving child care. Throughout these years we have tried to cover certain basic topics in our training program.

These have been:

1. Mental (emotional, social, and intellectual) growth and behavior from birth to maturity, in the light of the interplay of hereditary, constitutional, psychological, and cultural forces occurring in the development of each person from conception onwards.
2. The psychological implications of child-bearing, of education, and of child care in health and in sickness, especially in terms of the parent-child and other personal relationships.
3. The psychological concomitants of physical illness and the psychological rôle of physician and nurse in parental guidance and in the medical treatment of sick children and adolescents.
4. Deviant personality structure and psychopathology (especially in psychosomatic disorders) with emphasis on the genesis, prevention, and treatment of emotional difficulties and the so-called behavior problems of all age-groups from birth to adolescence.
5. Opportunities for psychotherapy in pediatric practice, particularly through such commonly used techniques as history-taking and physical examination; the limitations of such methods; the methods of preparing patients for treatment by psychiatrists.
6. The influence of social, economic, and cultural factors on children and parents.
7. The contribution of the social sciences to the improvement of child care.

Our methods of teaching these principles have varied over the years. At first our trainees consisted of pediatricians who had had at least two years' training in orthodox methods at an accredited pediatric center. These post-graduate students had definite teaching posts to return to on completion of their training. They began their learning experience in a psychiatric ward for adolescents and young adults, where they could

see gross psychopathology demonstrated and begin to see the outcome of neurotic and psychotic illness. They also had an opportunity to study the origins of these illnesses and to note whether there had been any basis in infancy and childhood for their development. Clinical work was associated with seminars and supervised conferences about individual patients. The time spent in the general psychiatric clinic varied from four to nine months. After that the trainee took up work in the psychiatric out-patient department and in the pediatric clinic. He continued, however, with his patients in the psychiatric wards in order to get a comprehensive view rather than fragmentary observations.

In the psychiatric out-patient department each student (under supervision) was assigned children and patients who came with problems of behavior of the kind ordinarily seen in such a service. Work with these patients was carried on until the end of the second-year training period, covering roughly a span of 15-20 months. The emphasis here was not on making the trainee a child psychiatrist, but rather on introducing him to persons with problems and on giving him some insight into the nature of these individuals and the effect their problems might have on child-rearing and child care. It also brought the trainee into close touch with practicing child psychiatrists, social workers, and psychologists, enabling him better to appraise their rôle in the diagnosis and treatment of behavior difficulties. Very often this was the first opportunity a pediatrically trained physician had of first-hand contact with a psychiatrist. Concurrently with this period in the psychiatric department the students worked in the pediatric department, particularly the well-baby clinic, the adolescents' clinic, and the general sick children's clinic, both in-patient and out-patient. Efforts were made to keep the case load small, so that adequate time could be spent with each patient, and the cases were followed as long as possible, enabling the student to observe the changes which come with age and maturity. Physically sick children were cared for, always bearing in mind that they were individuals in whom the psychological and physical elements interacted. In our attempt to teach comprehensively and to include the psychological elements we tried to maintain an awareness of the importance of the body, its function, and its anatomy and pathology. It must be emphasized repeatedly that in the teaching of medical psychology to non-psychiatric physicians nothing must be lost which has been gained from scientific medicine in the diagnosis and treatment of physical illness. To insure this as far as possible our method of teaching was to emphasize that the medical and psychological approaches were best made through the traditional medical procedures, namely, history-taking and physical examination.

Although these methods were stressed as fundamental to the study of the patient, whether the problem were physical or psychological, it was also necessary to demonstrate that changes in the traditional methods of history-taking are required in order to appraise a patient as a human being. History-taking must be considered as a form of interview, with important therapeutic implications; further, a thorough physical examination has its therapeutic as well as its diagnostic implications.

These trainees, after spending two years in post-graduate work relating psychiatry to pediatrics, left to assume different positions in public health or pediatric departments; some went on for further training in psychiatry in order to become fully qualified in that field.

Concern was felt over those pediatricians who took on the rôle of child psychiatrist in departments of pediatrics without sufficient training to qualify them. It has been found that the trainee who functions best after his post-graduate experience is the one who continues to be associated with pediatrics in his practice, and who is accepted in a department of pediatrics as a pediatrician. Within this framework he is able to teach growth and development, the meaning of behavior, and the other aspects, doing this safely, without confusion to himself or his colleagues. In order to promote the development of such pediatricians and in order to safeguard them as well as the patients, our training program was reduced from two years to one year. This was accomplished by omitting the training in the department of psychiatry and limiting experience to that of the pediatric ward and out-patient department. In this way, the student is constantly reminded that he is a pediatrician working within the field of pediatrics. After several years of further experiment with a one-year training program, it was felt that the time had come when special programs of post-graduate education in pediatrics for persons desirous of learning about psychological medicine no longer served a purpose. As a result, the Department of Pediatrics of the Yale University School of Medicine has concentrated on making available to every pediatric resident the opportunities which formerly came only to these special trainees.

At the end of a two- or three-year pediatric residency it is hoped that our trainees will have at much understanding of growth and development, behavior, and parent-child relationships as of the physical elements of medicine emphasized in diagnosis and treatment. No matter what the patient, our day-to-day teaching is intended to bring out the mental as well as physical aspect of each case. For example, in ward rounds consideration is given not only to the child's pneumonic processes, but also to the influence of his illness on how he feels, on his behavior, and on his relationship with his parents. In his convalescence we are concerned not only with the resolution of his physical signs, but also with his return to good physical and emotional health and with his ability to join his family and his friends in a fully functioning rôle as soon as possible. In the hospital we are concerned with the psychological management of the physically sick child; we have relaxed restrictions on visiting, included living-in arrangements for some parents and children and care of infants by their mothers, and have provided adequate recreation and occupational therapy opportunities for the bedridden as well as the ambulant patient. Our in-patient rounds tend to be rounds made by groups of persons with different professional interests, including pediatrics, psychiatry, sociology, psychology, and social work; they consist of informal discussions with contributions coming from junior personnel as well as senior staff, the leader being the pediatrician-in-charge.

Another method used at Yale to teach "growth and development" is one which introduces the pediatrician-in-training to the practice of medicine outside the hospital. Each intern, on starting his service, follows the last trimester of pregnancy of a woman who has volunteered to accept him as her pediatrician. The pediatric intern meets the pregnant woman and her husband once or twice to learn the history of the pregnancy and come to understand the couple and their aspirations as future parents. Whenever possible the intern witnesses the delivery and notes

the mother's reactions to her labor and to the birth of her baby. From then on he becomes the family pediatrician as long as this remains mutually agreeable to parents and staff. During the next few months, although the infant and his parents are seen regularly in our well-baby clinic, the intern is also available for home care at times of illness. In this child-care program each intern is under the direct supervision of an assistant resident who acts for him in emergencies when he is not available. Before routine visits the intern and assistant resident are briefed on what to expect and how to deal with certain problems which may arise; if, in the course of the visit, active supervision and consultation are required a senior member of the staff is called in. After these visits there are staff meetings for the entire pediatric resident staff, senior and junior, as well as others, such as child psychiatrists, psychologists, and social workers in the department of pediatrics. Frequently one or two of our nursery school teachers are also present. In these sessions patterns of behavior and growth and development are discussed, using the cases as illustrative material. This method of presentation is the more valuable as the children are known to the pediatric trainee and these aspects of pediatrics are better brought out and grasped than if presented in a didactic form.

An important section of our program consists of training in the pediatric out-patient department. Under the leadership of a child psychiatrist, pediatricians in training and medical students gain experience in dealing with ordinary child patients coming to a general pediatric service. Patients with minor behavior difficulties are not referred to psychiatrists; they are kept under the guidance of the pediatrician in training and his supervisor, who attempts to demonstrate how the non-psychiatric physician may deal with them adequately and safely. The child psychiatrist in charge of this training is assisted by a social worker skilled in medico-social and child-guidance work. They are joined in conference from time to time by a psychologist, particularly when mental testing has been arranged. Bi-weekly conferences in the clinic are led by this multi-discipline team so that the pediatrician in training, the medical student, and nurses may together learn how to work effectively with all patients. In this way the out-patient service in the department of pediatrics becomes more than a mere clearing-house through which patients pass to special clinics.

Towards a new synthesis

Competence in the care of sick children is no longer enough, although that is an assumed requisite, nor is a formal knowledge of growth and development. We have attempted to broaden the field of interest so that the pediatrician can both contribute to and learn from many other professional and lay groups which also care for children's needs. We feel that one of the obligations of an academic department of pediatrics is to synthesize and correlate the information and techniques developed in these other disciplines and to present them as a synthesis to the pediatrician in training, so that he can employ it in a helpful and practical manner.

Discussion

It was generally felt that Dr. Senn's method of training was highly desirable. A few members of the group from other countries had already started somewhat similar training schemes in their own hospitals, though they were as yet in a very experimental stage. Others pointed out that in their countries there were no psychiatrists trained to work with children, and at the same time their pediatricians had no knowledge of psychology. In view of this they were faced with an acute problem when it came to initiating a training program along the lines indicated by Dr. Senn.

The discussion, therefore, developed around the elementary principles upon which an *ad hoc* training program could be built.

The Technique of Consultation.—The first and most important factor that will influence the student, nurse, or pediatrician in training is the attitude of the head of the department, the professor of pediatrics. It is only if he fully appreciates the causes of emotional disturbance in the child and is cognizant of the stages of emotional development that a similar awareness can be transmitted to those who learn from him.

Students, at an elementary level, can acquire much that is of value through the method described by the late Sir James Spence as the "technique of the consultation." They watch the experienced pediatrician and listen to his way of speaking to the child in a conversation that may appear quite foolish to the uninitiated; they note his way of establishing initial contact and learn that the child is not a miniature adult — that he must be treated differently, as befits his age and understanding. The student also has to learn that the treatment of the child starts with the initial interview, just as in the work of a surgeon rehabilitation begins with the arrival of the ambulance. Every gesture of the pediatrician plays its part in the success of the treatment.

The old method of history-taking, where the chief complaint is conscientiously noted, inquiries are made into the history of the present illness, and the family history obtained in due course, is now being abandoned for a much more permissive technique. Experience has shown that histories obtained by rigid questioning often amount to little in terms of accuracy and give but small indication of family relationships.

The newly-qualified doctor tends to treat his patients unfeelingly and mechanically; being as yet unsure of himself, he is afraid to depart from regular procedure and adapt himself to the individual needs of his patient. If, on the other hand, he becomes aware of the existence of these problems through working in a good pediatric department, a point is sometimes reached where he is fearful of doing anything to his patients in case he causes some psychological trauma. He has to combine humanity and sympathy with acceptance of the fact that painful procedures are at times inevitable in the practice of good medicine.

It is one thing to encourage a student pediatrician to establish good relationships with children; some do so intuitively, while others must acquire the skill through an intellectual approach, studying and learning from their seniors. It is, however, another matter to lay before the student the vast area of scientific knowledge about emotional development, cultural norms, and family life. Nevertheless, even where there is no immediate possibility of organizing a training program in this field, it is possible to cultivate a new approach to the child, and this can pave the way to the introduction of such a program at a later date.

The Comprehensive Approach to Training.—In 400 B.C. Plato complained that modern doctors were splitting the psyche from the soma. Today, it was noted, doctors are not only dividing, but even fragmenting, the human being.

There is, moreover, a tendency to ignore the psyche. How many universities will offer a professorship in pediatrics to a man whose interest lies at least as much in studying the behavior and emotional development of the child as in the physical and pathological aspects?

It is to be regretted that research workers in the field of human behavior often cut themselves off from the actual milieu for which they prescribe. There are two sets of standards — one in the scientific field of the study of human behavior, another in the practical field of medicine and psychiatry. While this gives the research worker a certain detachment that may have its value, it also narrows the field and limits the application of his work in collaboration with other professional people.

Obviously, one individual can no longer contain within him-

self a fraction of the knowledge which exists about the working of the mind and of the body or the sum total of the individual's needs. No matter how these needs may have varied from age to age and from place to place, Plato's man has remained fundamentally the same, a simple being. He may be physically a little taller and mentally more alert, but his heart, his brain, his liver are in the same relationship to each other, and his feelings of love and hate, fear and security, remain much as they were.

Therefore a comprehensive approach to the individual patient is required. This can be achieved by a form of team-work designed to synthesize the fragmentary disciplines that have developed in modern medicine. But it also demands a broader knowledge and understanding on the part of the physician primarily concerned with children.

The methods outlined by Dr. Senn have shown how this can be brought about. There is little doubt that group work and group discussion result in far more valuable all-round experience and knowledge than didactic lectures or formal ward rounds, during which the head of the department instructs a vast gathering of students, interns, and members of the nursing staff.

Much more could be taught if inefficient teaching routines were dropped. This does not mean a clean break with the past, but more carefully planned teaching techniques and a better appreciation of what the student ought to learn. In fact, where there is no psychiatric team working in the children's hospital, the pediatrician in training, after making a study of the normal child, should later spend a year in a child psychiatry department, a child guidance clinic, or both. The purpose of this would not be to produce a hybrid "psychopediatrician," but to enable him, for example, to recognize a case of schizophrenia in its early stages and to be familiar with behavior problems and anxiety states. It is also desirable for the pediatrician to have access to some theoretical knowledge of psychoanalysis and first-hand contact with the practical problems involved.

Finally, the pediatrician must know what task each different expert can accomplish, which aspect of his patient pertains to the psyche and which to the soma. He must not merely be concerned with sick or delicate children, but with the entire

development of the normal sturdy specimen of humanity. He has to equip himself to be the "synthesizer."

Conclusion.—In order to achieve the all-round treatment in hospital that is necessary in the best interests of the child, the specialized training of the pediatrician should be considered in the light of the following points:

1. The principle that the physical and mental aspects of child health cannot be separated should be inherent in the whole training program.
2. This principle should be demonstrated through teaching methods where theory and practice are integrated in the greatest possible degree. To this end a critical review of a number of long-established teaching routines is desirable.
3. The pediatrician, as the specialist primarily responsible for the child's treatment, should either do his training in a children's hospital where he can work with a psychiatric team or, in default of this, spend at least a year in a child's guidance clinic, so that he may acquire a general knowledge of the child's emotional development against the background of family life and cultural norms.
4. Where resources are not available to establish a comprehensive program of training along these lines, much can still be done through the example of heads of departments and the use of a "technique of consultation" to promote a more comprehensive approach to the child and prepare the way eventually for a more fully organized training program.

The Training of the Child Psychiatrist

The basic clinical training of the child psychiatrist did not come under discussion. It was assumed that this would include mental-hospital experience as well as practical knowledge of psychological and neurological medicine, possibly acquired in the out-patient department of a general hospital. The length of time spent on this training naturally varies in different countries. Experience with mentally deficient children is not always regarded as essential in the psychiatrist's training. The study group, however, considered that this was an important part of his work and that appropriate training should be provided.

If it be assumed that these essentials are covered, there are other aspects of a psychiatrist's training which at times appear to be entirely omitted from the curriculum. One frequent deficiency in training is a lack of experience in pediatrics and the life of a children's hospital.

All were agreed that a child psychiatrist's training should include at the least a year's pediatric experience. But what kind of experience? During his period of training he may well acquire skill in the treatment of diabetes, the endocrine disorders, or blood diseases, but unless he remains in very close contact with pediatrics he will soon become out-dated. It is much more important for him to work in a pediatric center where he can be taught the dynamics of growth and development and learn at first hand about the infant and child in their different phases and reactions to illness. Moreover, the psychiatrist needs experience with children in the nursery school and in family surroundings, as well as in the hospital. Ideally, he should have some grounding in this work as a medical student. Later practical training in this field could be organized during his period of attachment to a pediatric department. This phase will, therefore, need very careful planning if it is to be of real value to him.

There is, further, a need for the psychiatrist to be well versed in cultural anthropology and sociology. He must have a sound knowledge of the family and cultural life of people around him if he is to bring the full value of his discipline to the work of a pediatric team. Despite a high level of technical education, doctors often betray ignorance in these matters. In the case of psychiatrists this is only now beginning to be modified through pressure from other members of the psychiatric team, the social workers and the psychologists, so that they are coming to accept the need for a broader outlook. Here it may be apposite to note that the differences in social and cultural background from one country to another make psychiatry a difficult discipline to transmit, and that training in one country does not always suit the needs of another.

Psychoanalytical Training.—Should psychoanalytical training form a part of the curriculum? One member of the group posed this controversial issue in the following way:

"I think we should demand the highest possible standard of training for the psychiatrist since, in this field, all the information which we pediatricians, nurses, and eventually the general public, are going to have, must needs come from him. For that reason I feel we should emphasize the need for the psychiatrist to have an extensive training in dynamic psychology, a discipline that has developed from the findings of psychoanalysis. We must recognize that we are living in a post-Freudian age and a great deal of what we consider common sense now was new and sensational 40 years ago; otherwise we are refusing to accept something which has influenced the whole of our thought in modern times."

This led to the discussion of two points. How far does psychoanalytical theory influence the practice of child psychiatry? And, what psychoanalytical training should the psychiatrist have?

As far as the first is concerned, there seems little doubt as to the need for psychoanalytical knowledge in the practice of child psychotherapy. A certain number of children need authentic, orthodox analytical treatment. This takes a great deal of time and should only be given by highly skilled specialists. But the psychotherapeutic treatment of most children who attend child guidance clinics, although in the orthodox sense not psychoanalytical, is largely based on this knowledge and the study of interperson relationships that is its complement.

Can this knowledge be obtained by theoretical teaching and observation?

In part it can. It is not unknown for psychiatrists, pediatricians, and social workers to carry out their work as though engaged in an apostolic mission; they often tend to be too protective or to identify themselves too much with their patients. Psychoanalytical training teaches the psychiatrist to maintain an inner detachment, allowing him the freedom necessary to a wise handling of each case. It helps him to a better understanding of the child's behavior, of the development of the mother-child relationship, and enables him, in his relationship with children and parents, to maintain an attitude conducive to the maximum therapeutic success.

The growing importance of group work and group therapy with children, parents, and students, where a clear picture of interperson relations is essential, gives psychoanalytical training particular significance.

However, a knowledge of psychoanalytical theory and observation of its practice cannot replace actual experience through personal psychoanalysis. In every country where psychoanalytical training is given it is a recognized rule that the trainee must undergo personal psychoanalysis as an indispensable part of his training. This is not merely a routine procedure. Through this experience the trainee learns how he reacts in all the vital situations in which he may be placed and how he tends to project his feelings. It makes him aware of influential hidden factors in his own past life, and this, in turn, leads him to understand many things about children with which he will be concerned later on.

In present-day psychoanalytical treatment greater emphasis than ever is being placed on the immediate interperson relations between the psychoanalyst and his patient. A prolonged study of this nature enables the future psychoanalyst to understand what is going on between himself and his psychoanalyst. Strongly positive and strongly negative feelings are aroused (transference and counter-transference), the proper understanding of which is of great significance alike for satisfactory team-work relationships and for successful therapy.

The question thus arises whether every child psychiatrist should undergo personal psychoanalysis in training. In many countries this will be quite out of the question, since no trained psychoanalysts are available. Even in countries where psychoanalysis is practiced by well-trained specialists, the number available to give training analyses is limited.

There are some in all countries for whom the experience will be the opposite of therapeutic. A psychoanalyst skilled at his work does not take on anyone for treatment or training without distinction. He will first study the personality of his patient and will undertake an analysis only if he is confident of its therapeutic value. This does not mean that some child psychiatrists, who for any reason have not undergone personal analysis, cannot be satisfactorily trained in the psycho-dynamic principles founded on psychoanalysis. It was generally agreed that all child psychiatrists should receive this training.

Practical Training Difficulties.—A difficulty inevitably arises when it comes to fitting this manifold training program

into a period of reasonable length. Nevertheless, the problem does not seem insurmountable and the following suggestions may go some way towards their solution:

1. Teaching on common family relationships, general development, the more usual kinds of emotional disturbance, and the effects of illness on people, together with some general anthropology and sociology, are all subjects in which every medical student should have some grounding. If they could be included in the student curriculum, the burden would be lessened in the post-graduate stage.
2. Psychoanalytical training, which normally extends over three years, could be carried on simultaneously with other facets of the trainee's work, including his period of pediatric training.

Conclusion.—To sum up the feeling of the study group, it should be a part of the child psychiatrist's specialist training to have:

- (a) a knowledge of the cultural patterns of behavior and emotional development;
- (b) carefully planned training in pediatrics;
- (c) an ability to diagnose and treat both adults and children as a result of his psychiatric and neurological training; and
- (d) in the majority of cases where feasible and reasonable, experience of personal psychoanalysis, in order to be able to use and promote an understanding of psychoanalytical principles.

It would be unfortunate were the child psychiatrist to aim at becoming a hybrid "pediatric-psychiatrist." The extent of training and experience advocated would make big demands on the trainee. At the same time it must be recognized that child psychiatrists, like most specialists in other branches of medicine, need to spend a number of years in training if they are to be adequately qualified and competent. In the words of one of those present:

"The problem of mental illness in many countries of Europe today is of similar magnitude to that of physical illness in tropical parts of the world. There is an acute sense of the need to have specialists to deal with this. There is intense pressure from the lay public. The possibility of providing qualified help is not good. It seems important that the rela-

tively few specialists there are, besides being clinicians, should be given the chance to act indirectly through the training of future doctors. For this task they themselves need the best possible training and qualifications."

The Training of the Pediatric Nurse

In view of the essential need for team-work in pediatrics and child psychiatry and the important rôle of the nurse in this work it was felt that her pediatric training should also be reviewed.

Pediatric Nursing at Yale.—As a preliminary to the discussion, nursing education at Yale was described. Here students are recruited from two sources. In one case they are chosen by the School of Nursing from applicants with two or three years of university work behind them, who, on completion of their course, receive an academic degree, that of bachelor of science in nursing. In the other they are high-school graduates who come direct to the School of Nursing attached to the hospital.

Candidates must be in good physical health and, as far as can be determined, emotionally stable. Emotional stability is not always easy to assess accurately, but throughout their training it is borne in mind that they are subjected to experiences which may well be upsetting and that they should have ready access to help in case of need. This is normally provided throughout their training in regular meetings with the faculty, where they can talk about themselves, their plans, and so on. Occasionally, a nurse is found in this way to be mentally sick or emotionally disturbed. In such cases her training is suspended and she is given help in obtaining psychotherapeutic treatment.

The three-year training covers both theoretical and practical work, and during the second year students spend time in the pediatric department—usually six months, or more if they wish to specialize. During their pediatric training they receive lectures from pediatricians and discuss the physical care of children, the common diseases, their diagnosis and treatment. They are observed as they work with patients and are trained in "growth and development."

At one time there was a series of six two-hour sessions in this subject, the infant and child being described from the

standpoint of their development, with special reference to the findings of developmental examinations. This approach, however, did not arouse the interest of students; the knowledge was not related to their practical work, and it gave them no understanding of their patients as human beings. It proved, in fact, too mechanical and was abandoned.

Student nurses are now placed for a short time, about two weeks, in a nursery school for healthy children where, under supervision, they observe the children. Each observation period lasts for three hours and is followed by a session when the observations are discussed and the students questioned about what they have seen.

In addition each nurse spends two weeks as a play nurse (not wearing her hospital uniform), working with the full-time play worker in the wards. She is assigned one patient each day and keeps detailed notes to help her to look, to listen, and to record. She helps the child at meal times, plays with him, and puts him to bed. When working in a clinical rôle as a "bedside" nurse she accompanies the medical staff on their daily round and is encouraged to ask questions and join in the discussion as an important member of the team.

One of the most valuable features of the training has been the weekly conference of all the student and graduate nurses attached to a ward. Here they talk about their special problems and ask why one child will not stay in bed or why another has tantrums. Students are very receptive to suggestions made when they are personally involved in situations such as these; they are always asked to look beyond the obvious behavior and ask: "Why is this child acting in this particular way?" Emotional development is also studied, and it is brought home to them that in ministering to children physically they are also ministering to them emotionally, that every action has its meaning to a child although he cannot convey what he feels in words.

The theoretical course gives the nurses a more organized picture of emotional, intellectual, and social development as an inseparable complement to physical development and as having an effect on physical care.

At the beginning of their course they meet the professor of pediatrics in charge of the department. They are told by him of the stresses and strains they may have to face; how they

will probably react to their colleagues, their patients, and the parents; they are advised to behave spontaneously and not to feel they have to be impersonal in their care of infants and children; they are encouraged to pick up the child and caress him if they want to. They also know they can always see the professor of pediatrics in person if they want to discuss a problem or difficulty.

One important aspect is that of planning the training to fit in with the teaching of the senior nurses and supervisors. Post-graduate courses are arranged when asked for by senior nurses, and usually take place in the evenings in the home of one or other of the doctors. Here, in a friendly, hospitable atmosphere, nurses can discuss their problems and feel at ease in talking about their difficulties over the children, the hospital, or visiting hours. Whatever they may want to discuss more fully with the medical personnel, they have the opportunity to take it up quite frankly. This attention to personal difficulties during the nurses' training has brought its reward in that an increasing number of students ask to work in the pediatric department.

General Versus Specialized Training.—At Yale, nurses spend a considerable part of their second year of training in the pediatric department. On the other hand, a special type of nurse, the registered sick children's nurse, has been working in the United Kingdom for over 20 years. These nurses are recruited at the age of 18 and take their state examinations after three years' training at a children's hospital, without any experience in adult nursing. In its original form the Nurses' Act of 1949 would have provided for the abolition of all special nursing diplomas except for the midwife and the mental hospital nurse. As a result of representations, an exception was made for the sick children's nurse, but with the clear understanding that her training would be reconsidered at some future date and that the decision was in no way final. In order to meet the situation a comprehensive type of training has recently been established in London and other centers, as an experiment, whereby student nurses spend their first year in a children's hospital and their second at a hospital for adults, returning subsequently to the children's hospital to take their state examination, followed by

their examination for the children's register after one more year.

The point at issue is that a certain type of girl is drawn to child nursing and has no wish to nurse adult patients. If the sick children's diploma were abolished a valuable group of students might be lost. It has also been found that the student who chooses the care of sick children as her vocation is often far more receptive to the ideas of comprehensive pediatrics, including its psychological aspect, than a person who comes to pediatric nursing through a year's post-graduate training following three years' general nursing. If nurses are to be imbued with the sort of approach that is desirable in a children's hospital they must, from an early stage, come under the influence of its atmosphere. The same opinion has been formed from experience in Italy, where there are now two schools of training for nurses specializing in work with children. Those who train with adults are found to be less understanding of children's needs, whereas first-class results have been obtained by recruiting girls of 18 who have already had some experience with children in nursery schools or have had some higher education, and who wish to devote themselves exclusively to children.

Shortage of Nurses and Their Status.—Many members deplored the acute shortage of nurses in their countries, and urged that they should receive a better salary and be given a more attractive social status. Otherwise, it was argued, a vicious circle might develop, with understaffed hospitals, overworked nurses, a steady drain on the profession, and recruiting difficulties. In such circumstances nurses would be less receptive to a comprehensive psychological approach which might involve them in even further duties.

By improving the nurse's status, by accepting her as a full member of a team, drawing her into conferences and discussions, and improving her training and pay, there is every ground to hope that the vicious circle can be broken.

In Italy, with the improved status of pediatric nurses, who now receive a state diploma, the number of applications has been almost three times the number of places to fill.

In some countries the shortage of nurses is being overcome by the substitution of auxiliary nursing personnel for some of the functions ordinarily carried out by nurses. For example,

mothers or members of the nutrition department feed the babies more often than the nurses. During the late war, individuals not qualified as nurses were found to be highly efficient in the operating theater and are still so employed. The war has shown that auxiliary personnel of either sex can be successfully trained as assistants to surgeons.

Courses consisting of a year's training have also been organized for women not otherwise eligible for the profession to become paid "nurse-assistants." Mothers who have brought up their families make excellent recruits. The scheme has proved very successful and "nurse-assistants" bathe and feed the children and even give them simple medicaments, thus freeing a large number of nurses who are so urgently needed to tend sick children.

Role of Male Nurses.—In order to help overcome the shortage of nurses would it not be possible to recruit men? Might not the adolescent boy with a long illness or the small girl who misses her father gain from the care of a male nurse? In many parts of the world male nurses have proved their worth. An instance was given, in discussion, of a large hospital in Kenya where the pediatric nurses are all African males, working with European head nurses. For a number of years African women nurses have been employed but have proved less successful with the children than the men. This may be due to a different social and cultural pattern of life. No doubt, in most hospitals there is sufficient medical staff to provide father substitutes; but the question should be considered further, both from the standpoint of the shortage and in the light of the nurse's rôle.

Psychological Aspects of the Nurse's Training.—Consciously or unconsciously the psychotherapist tends to become possessive about his patients unless steps are taken during his training that will help him to combat this attitude. In the same way, the nurse tends to become a parent substitute, a pleasurable rôle and one which she is apt to guard jealously. Nevertheless, the mother, however far away she may be, guards her rôle even more jealously.

The subtleties of interperson relationships have to be conveyed to the nurse; there are a number of psychological phenomena she must understand if she is to achieve mature fulfillment of her rôle. For example, she will not be aware

of the phenomenon of regression in a child unless she is given insight into this. A child may not behave at all according to his age; he may be a four-year-old in his psychological behavior one day, and three days later behave like a seven-year-old. Although such reactions are to be expected on hospitalization, they are, nevertheless, not at all kindly tolerated in some countries where the child who has regressed and become infantile during illness is regarded almost with hostility and talked of with contempt.

A further example is the phenomenon of transference, where the child, needing an object to love in his immediate surroundings, forms a strong or violent attachment to the nurse in charge of the ward. This situation may give the nurse a great deal of pleasure; she becomes possessive about the child or sees it as flattering to her skill as a nurse, without understanding it in terms of the child's needs. Even more when the child becomes hostile the nurse must be helped not to feel it as a personal affront. She must be taught to understand it in the light of the child's psychological background.

An understanding of these situations can best be grasped through the teaching and example of a humane doctor. It is more easily achieved during training than later, when the nurse holds a more responsible position. If, when in charge in the ward, she is told that the way she is behaving is bad for the child, her personal pride may seem at stake and she will be less ready to accept what appears as a reflection on her work. It is not so difficult at the training stage to explain the pitfalls and say: "It is very easy as a nurse to want to take a child away from a mother, because you like children." She is then more likely to accept the implications of her special rôle, to assimilate new ideas, and to act on them at a later date. It is also important for a nurse to have interests and ties outside her work, as these make her less likely to become an aggressive mother substitute.

Reorientation of Trained Staff.—Perhaps the nurses least easily won over to the more individual and human approach are those whose training and experience have steeped them in routine procedure, especially those who have worked exclusively in a surgical ward. It is important that the surgeons working with children should give a lead in modifying procedures and attitudes. In this connection, most members felt,

it is preferable not to isolate surgical from general pediatric nursing.

The rigidity of procedure in hospitals for infectious diseases, where the nurses have a host of regulations to enforce, was also deplored by the pediatricians. How necessary, they asked, are a great many of these? Nurses should be given the opportunity to let in more warmth, and so help obviate the psychological traumata so easily inflicted in this restrictive atmosphere.

Conclusion.—To sum up the general discussion, the importance of the nurse as a member of the pediatric team was unanimously stressed. A number of clearly defined points on which there was wide agreement emerged from the discussion:

1. Nurses working with sick children should have had a major part of their training in a pediatric department.
2. Special attention should be paid during the pediatric training to the psychological aspects of a nurse's work, and she should be given the opportunity to participate as a fully responsible member in the pediatric team.
3. The status and pay of nurses in many instances is grossly inadequate and this is responsible for short-staffing and overwork. Only when this situation is remedied will nurses have time to consider the full psychological implications of their rôle.
4. There are various practical measures for alleviating the shortage of nurses, among them the substitution of auxiliary personnel for some functions that need not be carried out by nurses and the short-term training of nurse-assistants for the same purpose. The question of recruiting male nurses deserves careful consideration.
5. In many hospitals rigid regulations and the approach that they inevitably engender are detrimental to the tremendous contribution the nurse could otherwise make to the work of the pediatric team. A progressive and judicious relaxation of such regulations could greatly assist in promoting a new and more effective approach to pediatrics. Coercion is never successful in winning people over; all the members of the pediatric team must work together to humanize hospital care; they must

believe that hospital procedures can be usefully changed and understand why those changes are necessary.

COÖRDINATION OF PEDIATRIC AND PSYCHIATRIC SERVICES

The pediatrician trained in comprehensive pediatrics is alert to the many psychological factors to be studied when treating a child. In some cases he will feel competent to undertake all that is necessary, whether physical or psychological, but in others his knowledge of emotional disturbance, of anxiety states, and of behavior problems will lead him to call in a psychiatrist to give specialized treatment.

Apart from referring a child for therapy, he will at times require the *ad hoc* opinion of a psychiatrist about children in his wards, as he would that of the surgeon. However, in fairness to the psychiatrist it should be remembered that he can rarely give an "on-the-spot" opinion, since an accurate psychiatric diagnosis depends on prolonged investigation of the many psychological aspects of the case. Although he may know at once when a child is seriously ill, and recommend full investigation and treatment in a psychiatric department, it is not always easy to give an immediate opinion in borderline cases that may remain the responsibility of the pediatrician.

These considerations raise the problem of coördination between the pediatric and psychiatric services from the curative and from the preventive standpoint. As a basis for discussion the following case was presented.

Coördination in a Psychosomatic Case

Barbara, aged 11 years, first started to have attacks of asthma when she was nine months old. There was only one other case of asthma known in the family, three generations back.

Her attacks were associated with acute upper respiratory infections and continued after these had cleared. She first went into a hospital at the age of two years, but various treatments proved of little help. At three years her tonsils and adenoids were removed. Later, when four, she was admitted to another children's department with bronchopneumonia and on recovery from this was sent for six months to a sanatorium in the mountains.

It had been realized on her admission that she was difficult to manage, emotionally unstable, and at times very aggressive, but as the psychiatrist was working under considerable pressure a consultation was postponed until it could be seen whether a change of environment would prove beneficial. As this produced little improvement in her condition the psychiatrist saw her and her parents in consultation.

The psychiatric interviews revealed that the child's home life was full of tension. The father was a weak man who reacted to stress with headaches and vomiting.

The mother, born out of wedlock, had herself had a disturbed psychological history, and was lacking in self-confidence, though ambitious and conscientious.

Both parents had sought to force Barbara into independence when she was barely three, neither had given her the security or affection that she needed, and they were quite unable to cope with her illness.

She was admitted to the psychiatric unit for therapy, during the course of which she expressed her longing for a more affectionate response from her mother. At times she was extremely hostile and aggressive, but was allowed to express these feelings; at others she was filled with anguish and remorse. During this period her mother also received psychiatric treatment and gradually developed sufficient understanding and confidence to have the child at home for longer and longer periods, a marked improvement being shown in the relationship between the two.

As the years passed a deterioration occurred in her chest condition, although there were longer intervals between her attacks of asthma. Psychologically she remained in a happier state, adjusted herself to her illness and was amenable until recently when, with the onset of puberty, she again became depressed.

At this stage she and her mother asked for further psychiatric help.

The salient features of the case were, in the first stage (up to six years of age), emotional instability accompanied by a chronic asthmatic condition despite all efforts at treatment; the fact that she was so unmanageable was a strain on the pediatric department.

In the second stage (from six to 11), when the psychiatrist had been called in and psychotherapy was given, there were less frequent asthmatic attacks though the chest complications grew more serious.

While it was not possible to establish how far the psychiatric treatment had affected the physical aspects of the case, the psychiatrists concerned believed that the parents were given a different conception of themselves, their girl, and her disease, and it became possible for them to manage her through these exceedingly hard years.

When Should the Psychiatrist Be Called In?—In Barbara's case the psychiatrist was not consulted until an advanced stage had been reached. Assuming a psychiatrist to be available, would it be right to lay down a rule that a child should be sent to him only if physical treatment had failed to relieve the symptoms? Certainly, a pediatrician's training ought to enable him in a great many cases to calm the parents' anxiety

and to exert a beneficial effect on the child, but there is always the danger, when treatment is based purely on symptomatology, that this may not bring more than superficial results.

A psychiatrist cannot determine what therapy to undertake from symptoms alone; he has to consider the case in its entirety. He must know about family relationships and the home environment, and understand something of the child's reactions to these and to his illness before he can tell whether to recommend psychological treatment or not. The case of Barbara illustrates the impracticability of dividing diagnosis and therapy into two stages, one the concern of the pediatrician, and the other where the psychiatrist is called at a relatively late stage in treatment.

Thus, whenever the case is likely to be chronic and emotional factors appear to underlie it, it would be wiser to call in the psychiatrist at the point of diagnosis. It is not enough for him to take action at a later stage. A comprehensive diagnosis is the first major step in treatment. Had a psychiatrist, in Barbara's case, been consulted at the outset, it is possible that the physical therapy might have been more successful. At the least it is probable that the pediatric department would have been able to treat a far more manageable child.

Early Recognition and Preventive Measures.—In the case under discussion irrevocable damage occurred at an early stage. What solution is there for the many similar problems of this kind that are continually arising?

The answer surely would lie in preventive measures. Had this mother received adequate help when her child was still an infant it is possible that much suffering and distress might have been averted.

The preventive services, however, are in many cases still ineffectual, and the shortage of psychiatrists must be borne in mind.

In Sweden and the U. S. A., for example, asthma is so common that it would be impossible for the available psychiatrists to give consultation in all cases.

Pressure of work creates a vicious circle which would be alleviated, in part at least, if early recognition of psychiatric cases could be more widely assured.

Here, an illustration of what could be done was given from a polyclinic for asthmatic cases in Helsinki. At this clinic a

psychiatrist and a social worker have been appointed as members of the staff to see all cases and give them out-patient treatment whenever investigation justifies it. The results have been most satisfactory.

Other methods, too, can help to insure early diagnosis and thus obviate time-consuming treatments. Several pediatricians referred to the "multiple rounds" described by Dr. Senn, and also practiced in their own wards with psychiatrist, social worker, and psychologist in attendance. These have been found of increasing value, not only in helping the pediatrician in his work, but in enabling the child psychiatrist and other members of the team to keep in touch with problems of physical medicine.

If a full-time psychiatrist is appointed to work with the team he can always be present and act as assistant to the pediatrician, both in the out-patient department and on rounds; if, on the other hand, he is appointed as a part-time worker he will be able, as in one London pediatric hospital, to go round the wards once a week with the resident doctor and discuss with him any problems that arise. In this particular hospital he also does a full ward round once monthly with a physician and discusses points or makes suggestions regarding the diagnosis, treatment, or general handling of children. This flexible and informal arrangement has helped towards obtaining early recognition of psychological problems, and has also been useful in reassuring the pediatrician when other children, about whom he has doubts, do not require psychological treatment.

In another instance, at Oslo, the psychiatrists go round the wards twice weekly with the senior pediatrician, who discusses with them any cases he considers in need of psychiatric help. Once a week the psychiatrists see the new admissions to the pediatric wards and give general consideration to the case of each child. Every other week a joint staff conference takes place, attended by pediatricians and psychiatrists, where cases of special concern to the latter are discussed and decisions made as to treatment and responsibility for their future care.

Coördinating the Work of Two Departments.—The rôle and status of the psychiatrist and his relations with the pediatrician are of the utmost importance in the coördination of

their two services. Should the psychiatrist be a member of the pediatric team—an assistant to the pediatrician—and in charge of a closely related child psychiatric unit as, for example, in Stockholm? Should the child psychiatric department be part of an adult psychiatric department as in Paris? Should the unit be independent, as in Groningen, where it is near both the pediatric and adult psychiatry departments, and is easily accessible to both?

While child psychiatrists should be competent to treat adults as well as children, in certain cases where there is a suicidal or grossly disturbed parent needing institutional care, treatment by "adult psychiatrists" will be called for. This is doubtless a point in favor of some association with the adult psychiatric department.

The pediatricians were strongly in favor of having a child psychiatric team closely associated with the children's department, in order to maintain the link between the two disciplines. The psychiatrist would then attend staff meetings, work in the hospital and its out-patient department, and be more readily available to make decisions. He would be in closer contact with the medical and nursing staff and be able to exert an over-all influence.

The child psychiatrists, on the other hand, made the point that a completely independent department was essential in many cases. It should, ideally, be as near as possible to the hospital, but its independence from the pediatric department is necessary because the child psychiatric clinic has an atmosphere and is conducted in a way that is peculiarly its own. It is necessary to have a more relaxed atmosphere than can possibly be achieved in a children's hospital.

The eccentric behavior of disturbed children—the over-activeness of some, the withdrawn attitude of others—has to be tolerated during psychotherapeutic treatment in a way which may cause havoc in an ordinary pediatric out-patient department. This may apply only to those relatively few children who are seriously disturbed, but they need the appropriate treatment none the less.

A major part of the psychological work with children takes place in child guidance or similar clinics, and it is only during the last few years that pediatric departments have opened

their doors to the psychiatrist. Many cases normally seen in child guidance or similar clinics have no need to be associated with a pediatric department.

The great majority of children with behavior problems and anxiety states are sent to these clinics. Most of them are physically healthy, in spite of opinions which may have been expressed to the contrary, and they seldom find their way to hospital. Sometimes, however, family doctors and parents are happier to make the first contact through a pediatrician who will then refer the child, if indicated, to the psychiatrist.

There is the difficulty that when the psychiatrist sees a child in the hospital, especially in the absence of the parents, he is seeing him in an artificial environment which, strictly speaking, is contrary to good psychiatric practice. Consequently, he may well fail to get the true picture he requires. Moreover, the hospital atmosphere, in giving a temporary sense of security, may obscure the nature of the child's anxiety. This again brings out the need for the psychiatric unit to be located independently of the pediatric department.

Ideally, the solution would seem to lie in the psychiatrist's assisting the pediatrician for part of his time, not only to give of his expert knowledge, but also to remain in touch with the atmosphere of a children's hospital and know at first hand what the child is experiencing.

For the rest of his time he should be able to work with his special equipment and special techniques under different conditions and in a different atmosphere.

An arrangement of this character would save him from his too frequent tendency to isolate himself in his clinic. On the other hand his work at the clinic would prevent his becoming too deeply immersed in the specific type of problem which is met with in a children's hospital.

Conclusion.—The main points on which there was a general consensus were as follows:

1. Whenever the pediatric department has to deal with a chronic disease and emotional factors appear to underlie it, it would be wise to call in the psychiatrist at an early stage.
2. Ideally, the adoption of preventive measures in infancy by the pediatrician, the family doctor, health visitor, or maternal and welfare services would be the best means

of avoiding the development of serious psychiatric illness.

3. Failing this, much can be done through the coördination of pediatric and psychiatric services to promote early recognition of such cases.
4. Both the above approaches could do much to alleviate the shortage of trained psychiatrists and the pressure of work on those available.
5. The child psychiatrist should advise the pediatrician, much in the same way as the radiologist or the pathologist does. The pediatrician would then be responsible for making a synthesis of the sum total of findings and for making the final decisions.
6. In cases where psychotherapy is necessary the psychiatrist should assume full charge of this, though continuing to collaborate with the pediatrician wherever that is indicated.
7. Where the child psychiatric unit is an independent one, it should be situated near the pediatric department, so that a two-way exchange may be readily brought about.

The Psychiatric Team.—What should be the function of a psychiatric team, and of whom, in addition to the psychiatrist, should it consist? In a number of countries it includes at least two other members, the psychologist and the psychiatric social worker. Recently, especially in university training centers, a number of teams have included sociologists and anthropologists and many of them add a non-medical psychotherapist and a speech therapist.

Before reporting the discussion on this problem and the case on which it was based, a brief outline of the training and rôle of psychologist and psychiatric social worker in one of the countries concerned may be of value.

The Training of the Psychologist in the United Kingdom.—The psychologist is expected to have an academic qualification in his subject, preferably at the honors level, and not as a subsidiary subject to philosophy. The academic course is a scientific one, concerned with the study of human behavior. It usually consists of a three-year undergraduate course, including experimental and practical, but not applied, psychology. The research findings in various branches of psychology, child psychology, and abnormal psychology are

studied, as well as such related subjects as physiology and philosophy. Applied work at the undergraduate level is not favored as this should come after graduation. A distinction is made between the fields of educational, social, occupational, and abnormal psychology, and any one of them can be chosen for applied post-graduate work. For training in educational psychology, the field most closely applicable to pediatric work, students, under careful supervision, spend a further year working part-time in child guidance clinics and part-time in schools, where they learn at first hand of the many problems teachers must face in dealing with children who are backward or maladjusted. Experience is also gained of various types of educational institutes and clinics during this post-graduate year.

The Psychologist in the Children's Hospital.—Here the psychologist's work is concerned in the first place with investigations, where requested, into the intellectual abilities of the patient. The psychologist is trained to carry out various tests which remain constant and are standardized for different age levels. The results can be considered valid only when the psychologist interprets them in the light of the relationship existing between him and the patient at the time of the test. First he observes and records the child's behavior; then he interprets these observations in the terms of his own science, and evaluates them; finally he considers the findings in the light of their general significance for the further development of the child. However, the report at the end of the investigation is not considered complete unless it is related to the findings of other workers such as the psychiatrist and the social worker. It is one of the psychologist's important tasks to do this and he is called on to assist in the interpretation of the sum total of the findings in joint conference and consultation.

Secondly, the psychologist is expected to interpret these findings to outside workers such as teachers and play-group leaders.

Thirdly, certain children, when the major cause of their conflict is educational, need reëducation or remedial teaching. This is a form of therapy educational psychologists are trained to give.

Further, through the nature of their scientific training,

psychologists are equipped to advise on the design of experimental research which may be undertaken in a hospital.

Finally, the psychologist plays a part in the educational side of any teaching hospital in lecturing to undergraduates, graduates, and nurses, and in demonstrating his part in joint consultations and rounds.

The Psychiatric Social Worker.—The basic training of the social worker in the United Kingdom consists of a two-year course in the social sciences and social welfare work. If she wishes to become a medical social worker she must take a further year's training in hospital routines and procedures related to her work. To become a member of a psychiatric team she must enlarge her experience by further training in the psychiatric field, with both adults and children. This course extends over 12 months, leading to an additional certificate.

The chief function of the psychiatric social worker lies in the understanding of interperson relationships and in their interpretation to the members of the family. She does not give medical advice, nor does she administer psychotherapy unless specially trained.

Besides assisting through routine history-taking and case work, the psychiatric social worker is a valuable aid in emergencies, for when an acute behavior problem arises she is able to have a preliminary reassuring talk with the mother to assess the urgency of the problem, and to arrange accordingly for a consultation with the psychiatrist. Her rôle as an intermediary is to some extent illustrated in the following case.

Team-work in a Case of Ulcerative Colitis

This case was chosen to show how various members of the psychiatric team could combine to help the pediatrician to a fuller understanding of the child's and family's attitude to the illness, and what the child's potentialities were in terms of emotional and intellectual maturity.

The case

Derek first came to the pediatrician when he was 4½ years old. He had a chronic history of frequent bowel movements and of passing blood and mucus in his stools since an operation for fistula in ano when eight months old. Each succeeding year he had been in different hospitals and

it was with reluctance that he was admitted once more for diagnosis and treatment of his anemia.

As for all cases of ulcerative colitis in this ward, the child psychiatrist was asked to see him and, in his instance, to indicate how he would react emotionally at this stage to an operation for resection of his colon, should this be suggested.

The intervention of the psychiatric social worker

In the meantime the parents were seen by the pediatrician and invited to see the psychiatric social worker before their psychiatric consultation. The reason for introducing the psychiatric social worker at this stage was not to relieve the psychiatrist of his responsibility for taking a careful medical history or for making the diagnosis, but because the psychiatric social worker was so trained to take a history of the child's development, home surroundings, and family relationships that the time of the psychiatrist was saved, and the parents were passed through an educative process which eased the resistances they had and were thus prepared for his consultation. Up to this time Derek's parents had, in fact, had a lot of aggressive feeling against both doctors and nurses who, they felt, had done little to relieve the illness of their child. All this they were able to express to the psychiatric social worker. They gave an uneventful history of his early life, but were reserved about their family relationships; any pressure of questioning would inevitably have brought out unreliable information and was therefore avoided.

The psychiatrist's intervention

The psychiatrist saw Derek in the ward and, as a result of his findings, advised that if necessary the operation should be done forthwith. He found that the boy was immature, retarded in development, and constantly preoccupied with his bowel symptoms. The impression he obtained that Derek was inhibited and abnormally docile was confirmed when he talked with his mother. He prepared her for the operation which she accepted as one more act in the drama of this boy's illness, in which all the family were deeply involved.

Further surgical investigation showed, however, that an operation was not advisable at this stage and Derek improved sufficiently to be discharged and to continue at home with a low residue diet, vitamins, and iron. He proceeded to gain in weight and 18 months later was passing one normal bowel movement per day and doing well.

Meanwhile, when the mother had gained complete confidence in the doctors she gave the psychiatrist the true history of his illness. She had seen blood in his stools when he was only five months old and had anxiously rejected the idea, only to be consumed with guilt later as his illness progressed—an indication of the difficulty of obtaining an accurate history from an anxious parent.

The psychologist's part

Derek's mother had been resisting the idea of sending him to school and it was now some months after he should have started. This was the time at which the psychologist could help, and her opinion was sought as to his intelligence level, his social maturity, and his ability to cope with school life.

At the psychological department of the hospital he was given the revised Stanford Binet test, as this was the one most commonly used in schools for educational assessment. This test indicated that at the age of five years and seven months he had a mental age of four years. Owing to his anxious and inhibited nature and his fleeting attention only a modest share of his innate ability seemed available, but this certainly gave some idea of how much he would be likely to achieve at school. It indicated that school activities other than those of the nursery class would be beyond his comprehension, and this was conveyed to the teacher. He was also seen again by the hospital child psychiatrist, who found that he had been making good progress during the previous year until a few days prior to this visit, when his mother had been unwell with an axillary abscess. He had clung to her more than usual, refused his dinner, and significantly had an increase in the number of his stools to five or six a day. His mother now had sufficient insight and understanding to deal wisely with him over this.

Some weeks later blood was noticed again in his stools for the first time in many months, and, in spite of efforts to keep him out of hospital by giving him chemotherapy, he had to be readmitted. Under anesthetic he was found to have developed another fistula in ano. As an inpatient on this occasion he was able to mix better with other children, to talk of more than his bowel activities, and to enjoy and profit from the hospital lessons.

The psychologist took this opportunity to assess his social maturity which was compared with the Vineland Scale. This showed that his competence to care for himself and participate in social responsibilities was also on the four-year level. Although he was very young for such a procedure he was shown the Bellak Test pictures, to see whether he would produce any fantasy or indicate areas of anxiety.

The fantasy test indicated that parent figures were benign to him, and it was concluded from the whole of the psychological examination that there was natural subdued aggressiveness in him which he was inhibiting for fear of retribution. However, there were indications that he was not firmly arrested in his development, and was attempting to grow up. These findings confirmed and reinforced the clinical impression which had been gained.

In this case there was no doubt that his mother had at first been using too much pressure in controlling Derek, reducing his natural, spontaneous activities to a minimum. Deeper and more prolonged psychotherapy would have been worth trying, but was impossible to arrange owing to the distance of the home from the hospital or any child guidance clinic. On the other hand, as a result of the work of the psychiatric team the parents, although aware that the outcome was obscure, had changed remarkably in their attitude to the doctors and were far more coöperative in doing what they could for the boy.

Discussion.—In the course of the discussion it became clear that some pediatric centers were in the habit of consulting psychologists at the diagnostic stage, without calling in a child psychiatrist. Nearly all the members of the study group felt strongly that this practice was most inadvisable.

The training of a psychologist gives him no medical experience to fit him to work independently of a psychiatrist in a hospital. Instances were cited of pediatricians requesting psychologists with little or no knowledge of psycho-dynamic mechanisms to make diagnoses on the basis of tests which, though lengthy and time-consuming, were of little value since they were mechanically applied. The results were presented without proper interpretation, as though they were final and irrevocable as far as the individual child was concerned, much to the detriment of his treatment.

The question arises whether, apart from the reëducational therapy already mentioned, the psychologist or the psychiatric social worker should give orthodox psychoanalytical or other specialized forms of psychotherapy to children.

The issue is a controversial one, but there would seem to be no reason to debar them from this work provided two important conditions are fulfilled.

The first is that the psychotherapist should receive the necessary prolonged training in the specialized therapy techniques over and above the training already mentioned.

The second is that the therapy, in either case, be conducted under the direct supervision of a child psychiatrist, and in close association with the pediatrician in cases where physical complexities are likely to arise.

Essentially, the safeguard lies in coördination, the work being apportioned among the team to each as he is most competent to do it.

Conclusion.—If the various specialists and specialized workers concerned with the psychiatric examination and treatment work independently of each other the history and clinical findings are inevitably less comprehensive and may lead to treatment of a grossly inadequate nature.

Experience has shown that a comprehensive picture of the child's psychological and emotional state in his normal environment is best obtained through the close collaboration of psychiatrist, psychologist, and psychiatric or other specialized workers. Only so can an integrated diagnosis and satisfactory therapy be obtained and the pediatrician benefit most from the work of the psychiatric unit.

ANNEX 1

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Prof. V. Rantasalo, medical superintendent, Amora Hospital, Helsinki

FRANCE

Dr. S. Lebovici, pédo-psychiatre, Médecin assistant des Hôpitaux de Paris

Dr. M. Lelong, professeur de pédiatrie, Clinique de Puériculture de la Faculté de Médecine de Paris, Hôpital St. Vincent de Paul, Paris

GERMANY

Dr. Annemarie Dührssen, child psychiatrist, Clinic for Psychogenic Diseases of Children, Berlin

Dr. H. Harbauer, director, Department of Child Psychiatry, University Clinic, Cologne

GREECE

Dr. S. A. Doxiadis, senior lecturer in pediatrics, University of Athens; pediatrician to the Alexandra, N.I.M.T.S., and Asclepeion Hospitals, Athens

ITALY

Dr. G. de Toni, professor of pediatrics, Children's Clinic, Gaslini Institute, University of Genoa

NETHERLANDS

Dr. T. Hart de Ruyter, professor of child psychiatry, Neuro-Psychiatric Hospital, University of Groningen

Dr. G. M. H. Veeneklaas, professor of pediatrics, University Hospital, University of Leyden

NORWAY

Dr. L. Salomonsen, professor of pediatrics, Children's Hospital, Rikshospitalet, Oslo

Miss Inger Schjander-Larsen, medical social worker, Children's Hospital, Rikshospitalet, Oslo

Dr. H. Wergeland, head physician, Department of Child Psychiatry, Children's Hospital, Rikshospitalet, Oslo

PORTUGAL

Dr. V. Fontes, director, Instituto Antonio Aurelio da Costa Ferreira, Lisbon

SWITZERLAND

Dr. A. Hottinger, professor of pediatrics, University of Basel

UNITED KINGDOM

Dr. R. MacKeith, children's physician, Guy's Hospital and Tavistock Clinic, London

Dr. A. Moncrieff, professor of child health, University of London Institute of Child Health, Hospital for Sick Children, London

YUGOSLAVIA

Dr. M. Ambrozić, professor of pediatrics, Faculty of Medicine, University of Belgrade

Cases were presented by:

Dr. R. E. Bonham-Carter, physician, University College Hospital and Hospital for Sick Children, London

Dr. Elsa-Brita Nordlund, head physician, Department of Child Psychiatry, Children's Clinic, Karolinska Hospital, Stockholm; assisted by Dr. Kihlblom Miss Grace Rawlings, psychologist, University College Hospital, London

Dr. Milton J. E. Senn, Sterling professor of pediatrics and psychiatry, Yale University, Department of Pediatrics and Child Study Center, New Haven, Conn., USA

Dr. K. Soddy, child psychiatrist, University College Hospital; assistant director, World Federation for Mental Health, London

Dr. A. Wallgren, professor of pediatrics, Children's Clinic, Karolinska Hospital, Stockholm; assisted by Dr. Kraepelin and Dr. Ström

Observers

Dr. Anna-Lisa Annell, associate professor, Department of Child Psychiatry, University Hospital, Uppsala

Dr. Sven Ahnsjö, associate professor, head physician, Department of Child Psychiatry, Kronprinsessan Lovisa Hospital, Stockholm

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Dr. Bo Vahlquist, professor of pediatrics, University Hospital, Uppsala

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Dr. N. D. Begg, director, Regional Office for Europe

Dr. D. F. Buckle, regional health officer, Regional Office for Europe

Dr. Mary Capes, child psychiatrist, consultant, Regional Office for Europe

Dr. K. Kjellberg, regional health officer, Regional Office for Europe

BOOK REVIEWS

A DICTIONARY OF PASTORAL PSYCHOLOGY. By Vergilius Ferm and others. New York, Philosophical Library, 1955. 336 p.

Vergilius Ferm and his associates have made a contribution to the organization of thought in the borderlands of religion and science in the form of *A Dictionary of Pastoral Psychology*. This dictionary, an ambitious undertaking, represents a subject that could have been vastly amplified through the work of additional experts on the editorial board. However, the six collaborators have produced a reference handbook of semantic merit and of practical helpfulness to busy pastors and indeed to other readers, lay as well as professional. The dictionary contains not only definitions of basic words and phrases currently used in religion, psychology, psychiatry, and allied disciplines but also short expositions of major schools of thought in these areas together with paragraphs on mental mechanisms, special techniques, historical references, etc. The volume contains bibliographical material and a simple cross-index system. In some respects, this dictionary is an encyclopedia in miniature.

An initial effort to collect pertinent facts from the complexities of the fields represented is bound to have limitations. A protagonist of a given school of thought might feel dissatisfied with the emphasis on this or that aspect of the specific field. A busy man might find it disappointing to look for a definition of "spiritual" and to find "spiritual concern: see success" or "spiritual life: see saintliness; success." He might look for a definition of mental health and find "see health, mental." In turn, he would find "health, mental" means "see adult, the; autosuggestion; mental hygiene; psychology of religion, religion and mental health." To someone with a relish for psychiatric nomenclature, the term "mental disorders" lists a hodgepodge of terms (for further search) which might tickle his funny-bone or irritate him. It is to be hoped that in the revision of this dictionary the authors will make greater use of discourse immediately following the word or phrase under study, thus following more closely the more formal tradition of dictionary construction. Cross-reference is important but may occasionally become bothersome if not handled in a practical manner. Perhaps erudite readers might desire more bibliographical material but a general practitioner in theology would do well to take advantage of the present suggestions as to reading.

One special group of references exemplifies the vision and spirit that have gone into this dictionary. At first glance the discussions on pastoral psychology under various headings might lead to a con-

clusion that no human being could achieve the attributes described as being associated with the pastor in functioning both as a person and as a professional worker. Full reflection on the discussions, however, enlarges the significance of the pastoral role in today's society and cannot do otherwise than challenge the pastor to think and to inspire him to serve. This dictionary brings its own moments of inspiration to the reader.

EDWARD J. HUMPHREYS, M.D.

Norristown State Hospital, Norristown, Pa.

SHOULD THE PATIENT KNOW THE TRUTH? A Response of Physicians, Nurses, Clergymen, and Lawyers. Edited by Samuel Standard, M.D., and Helmuth Nathan, M.D. New York, Springer Publishing Company, 1955. 160 p.

In schools of the health professions certain questions perennially arise that never seem to be settled. This is one of them: Should the patient be told he has a fatal illness? (Usually cancer is in mind.) In this book we have several different points of view, presented clearly, succinctly, and with conviction. Opinions range from discretion pending on the effect of the disclosure on the patient's condition and treatment to the out-and-out belief that the truth should always be told regardless of circumstances. Reasons for discretion are usually practical—on medical, legal, or religious grounds. Some patients do not want to be told and will not ask. Others will ask, but afterwards reproach the person who told them for doing so. Some will learn anyhow by inference or indirection. Cancer is by no means the only condition discussed; heart disease and neurological disorders come into account as well. *How* the patient should be told is brought out by some authors. It is heartening to see so little disagreement among such diverse authorities, particularly the representatives of different religions.

Unaccountably, social service workers are given no part in the symposium. Though they do not often have to discuss things with the patient, in our general and mental hospitals they usually have the task of telling the families what is wrong. This is at times more difficult than telling the patients. In fact, it is not uncommon, even in mental hospitals, to have the patient take unpleasant news better than anyone else concerned. We sometimes are treated to the scene of the patient comforting his relatives—and perhaps, occasionally, even the doctor! In a few places in this otherwise well-edited book misprints spoil smooth reading, most notably in this sentence from the Protestant clergyman: "Very often the dying patient . . . plays a part in the grizzly (sic) comedy of pretending."

This book should be useful to students and young practitioners in all those fields whose representatives come in contact with the seriously sick.

ROBERT A. CLARK, M.D.

Friends Hospital, Philadelphia, Pa.

LIVING AND LEARNING IN NURSERY SCHOOL. By Marguerita Rudolph. New York, Harper Brothers, 1954. 170 p.

Marguerita Rudolph brings to the writing of *Living and Learning in Nursery School* the experience of fifteen years of nursery school teaching and teacher supervision in various well-known coöperative schools. It is obvious to the reader that the author has observed children closely and sympathetically and has thought critically of the part that the teacher can play in helping them with their living at school, as well as with the complicated process of integrating the many experiences that life affords them.

In the introduction, Jessie Stanton points up the need to help young teachers see more clearly what small children are like—"their deep dependence on adults, their peculiar ways of making friends, their worries and fears as well as their delights and joys; their limited understanding, their fresh ways of seeing the world, their need at times for firm control." She feels that this book of Marguerita Rudolph's can help because of its careful descriptions of the ways in which children behave.

The book, in my opinion also, is especially well suited for the use of young teachers. I can imagine its lending itself very well to classroom discussion. The material in it opens up easily these questions: What are young children like? How can the teacher help them? What kinds of experiences can be opened up for young children in nursery school? I can see the book being equally useful to parents who are seeking answers to the questions of, "Shall I send my child to nursery school? What can I hope that he will gain from it?" It should be useful, too, to that ever-widening group of mothers who are taking their turns on duty days in coöperative nursery schools across the country. The book should make what they see on these days at school more meaningful to them; it should help them to see more; it should make them critical in a more intelligent way of the program of their particular school.

In part one of the book, Mrs. Rudolph discusses the beginning of nursery school and its meaning to children. She points up the difficulties for young children in leaving their mothers and the rôle of the teacher in helping them. She describes the struggles of the children to make friends and the development of friendly contacts between

teacher and children. The reader is given a glimpse of various activities in the nursery school and of the children's delight in sharing them with one another and with their teacher.

Part two of the book describes the nursery school curriculum in action. Out of her experience with the United Nations International School in New York City, Mrs. Rudolph discusses concepts and practices of democracy in the nursery school and children's understanding of each other through their interests and activities. In this same section the rôle of the nursery school in helping children toward broader creative activity in the sphere of art is discussed. Mrs. Rudolph points up too the child's spontaneous interest in science and ways in which the teacher can help him with his questions.

In the final section, Mrs. Rudolph suggests evaluation of the children's growth. She describes their imaginative play and their trying out of the rôles of father and mother. She feels that the teacher should keep records of the children's growth and that these should include first impression reports, progress records, and reports to the parents.

"For a nursery school teacher there is always a challenge to understand children better and it also is pleasure to be in their company." On this note Mrs. Rudolph concludes her book with a discussion of the nursery school teacher. The nursery school teacher can keep on learning from the children and through discussions with her colleagues and with parents. The reader feels throughout Mrs. Rudolph's pleasure in being with children, and it is this spirit that gives the book real charm.

FRANCES P. SIMSARIAN

Washington, D. C.

THE CAUSES AND TREATMENT OF BACKWARDNESS. By Sir Cyril Burt.
New York: Philosophical Library, 1953, 128 p.

The author's goal is to "survey what is already known and what has been accomplished, and then to summarize the main conclusions in a form available for the ordinary teacher. Thus, the immediate purpose of the book is practical rather than theoretical."

The text is, to some extent, an abridgement of a previous book (*The Backward Child*), and emphasizes that the treatment "of the dull and backward . . . must not only be sympathetic, but also scientific and, above all, based on a genuine understanding of the needs and aptitudes of each individual child."

The first two chapters deal with "The Problem and Its Origin," and "A Brief History of Child Study." They are well written and contain well-selected, quotable references to nineteenth century literary and philosophic opinions. Dr. Johnson declared that "stupidity is

commonly the result of stubbornness, and severity must be continued till negligence be cured. My master whipped me very well; without that, Sir, I should have done nothing," while Hobbes is quoted as saying, "The fool cannot be mended by flogging and he who flogs is a greater fool." When the national system of elementary education was introduced into Parliament in 1868, the notion of school for everyone was considered to be "a Utopian dream." Gladstone told Queen Victoria that he considered the author of the bill to be "a most impractical man." The Utilitarians considered "the low intellectual and moral condition of the masses" as a "secondary consequence of degraded conditions." James Mill stated that "if education cannot do everything, there is hardly anything it cannot do." But Carlyle argued that "everyday experience was sufficient to refute the new-fangled dogma of the equality of man."

The author describes the early experiences of Her Majesty's Inspectors (among whom was 'the apostle of culture,' Matthew Arnold), who examined pupils "to see how many failed to reach the 'standards' imposed by the Board's Code." The battle between the "hereditarians" ("once a defective, always a defective") and the "environmentalists" ("all that was needed was (sympathy and) a more adequate nourishment of both body and brain") must have been very bewildering to the average teacher. How classifications were developed, and how various grades of mental retardation were defined in terms of mental age, are clearly described. The author is one of the pioneers in the study and training of "backward" children. His first-hand account of the early attempts at child guidance in Great Britain and the history of the development of individual psychology are written with a personal appreciation of the great obstacles which stood in the way.

The book consists of eight chapters among which are, "The Methods of Investigation," "Environmental Factors," "Factors of Personality" (Physical, Intellectual, Emotional, and Moral Characteristics). The text contains many practical suggestions in regard to the handling of the mentally retarded child, and can be highly recommended.

JACOB H. CONN

*Johns Hopkins University School of Medicine,
Baltimore, Maryland*

THE ONLY CHILD—A GUIDE FOR PARENTS. By Norma E. Cutts and Nicholas Moseley. New York: G. P. Putnam's Sons, 1954. 245 p.

This book is written for all parents, but especially those who have only-children. Psychiatrists who are parents will want to read this book also. The book sets out to discuss the facts most likely to cause

trouble both in childhood and in later life, and suggests the practical steps to avoid dangers and build a healthy personality. In the United States, about one couple in six, of all those who ever have a child, has just one. About one child in twenty is an only-child. These figures are for absolute "Onlies." Of course, every oldest child is an only-child for a longer or shorter period. Other children in the family, when disparity of ages is great, may have the problems of an only-child.

"If a child is to fulfill his emotional need for group membership, he must have the satisfaction of knowing that he is accepted for himself and as himself by his peers. He must weather the storms that rise during free play among children: the persistent teasing, the brutal criticism, the fights, and the temporary exclusions. He must learn to compete for his due share of privileges and of honors. He must learn fortitude in the face of pain and disappointment, and endurance in the face of difficulties. He has to find out the values that children, like their elders attach to courage, initiative, and generosity. He has to learn to tolerate the idiosyncrasies of others. He has to be a good sport, eager to win but able to lose gracefully. He must learn to feel right about other people. The only-child is likely to be lacking in experience with other children, partly because he has no forced association with brothers and sisters, and partly because his parents get in his way. A few parents do this deliberately because they are afraid to let a child play with other children."

The authors have used the informal case method of interviewing parents of only-children and the children themselves. They have arrived at certain conclusions that are presented for the guidance of both the parents and the children.

This book is written in a clear, concise, intensely readable fashion that provides information in a most pleasurable way. It is recommended reading for any parent of an only-child, but all parents can profit from it.

WALTER E. BARTON

Boston, Mass.

NOTES AND COMMENTS

WORLD MENTAL HEALTH

World Mental Health is the quarterly publication of the World Federation for Mental Health. It is the mental health bridge between nations. Most of our psychiatric techniques—insulin, metrazol, electroshock and lobotomy, fever therapy, chlorpromazine and reserpine, antabuse, family care, Rorschach and Binet tests, and psychoanalysis have reached America from Europe by some such international bridge. *World Mental Health* costs but \$1.00 per year. World Federation for Mental Health, 19 Manchester Street, London W. 1, England.

CBS SCHEDULES TELECAST ON MENTAL ILLNESS

The Columbia Broadcasting System will present a 90-minute television show on mental illness—called “Out of Darkness”—Sunday, March 18, from 5:00 to 6:30, prime time usually reserved for Omnibus.

Since CBS and the National Association for Mental Health are cooperating in publicizing the telecast, it is expected that a major portion of the nation will see the show. NAMH has undertaken the specific two-fold assignment of distributing—through state and local mental health associations and cooperating organizations—millions of leaflets announcing the telecast, and of arranging 100,000 televiewing parties in homes and public meeting rooms.

Mental health leaders predict that the telecast itself, plus the extensive advance publicity already set in motion, will give sharp impetus to community plans for the nation-wide Mental Health Campaign for NAMH members and funds during May and for local observances of Mental Health Week April 29 to May 5.

“THE VALUE OF LISTENING, UNDERSTANDING, AND NOT JUDGING”

The doctor who is a sympathetic, trained listener will have the most success in patient treatment, it was stated by Dr. Lawrence C. Kolb, director of New York State's Psychiatric Institute, in a talk given at the North Shore Health Resort last March in Winnetka, Ill.

Discussing the “Value of Listening, Understanding, and Not Judging,” Dr. Kolb declared these qualities are “prerequisite to all intensive psychotherapy. . . . These techniques alone are inadequate to resolve the problems of all those who come to the office of the physi-

cian, psychiatrist, or psychoanalyst, yet their skilled and judicious application offer one of the most effective means available for aiding the emotionally upset."

Dr. Kolb observed that both experienced and inexperienced practitioners tend to give less time to patients' stories and more to ordering various and sundry tests. He stated that "unfortunately this type of medical practice is still much in vogue, but there has been a growing appreciation of the fact that emotional illnesses may manifest themselves as organic defects. The growth of psychosomatic medicine has emphasized the need to listen, question, and evaluate the statements of the patient rather than accept simple answers to routine questions."

Listening, he explained, is a technical accomplishment of high order that does not arise from natural endowment alone, but is conditioned by our own experiences. "Doctors must recognize signs of upsetting anxiety and their intensity," said Dr. Kolb, charging that "some patients in diagnostic consultations might well have been spared psychotic breaks if over-eager young physicians had listened."

LEGION SUPPORTS MENTAL HEALTH

Urging greater citizen participation in the mental health movement, the American Legion's National Child Welfare Commission hammered a mental health plank into its Child Welfare Platform at a national meeting October 7-8 in Miami, Fla.

"We recognize the high incidence of mental illness and of serious emotional disturbances as the nation's primary health problem," the platform notes. "We approve steps now being taken by both government and voluntary agencies to increase research and the training of personnel.

"We urge greater citizen participation in the mental health movement.

"Although mental illness is a broad, complex, and little-explored area, we urge that present knowledge of treatment and prevention, limited though it may be, be put to more complete use."

In other planks, the Child Welfare Commission called attention to "a close relationship between broken homes and the problems of juvenile delinquency and mental health," suggested a critical review of marriage, divorce and related laws and of marriage counseling services, suggested that schools consider ways to aid in preparing young people for family living, and urged support for expanded research and services for mentally retarded children.

DEDICATE NEW WING FOR ASTOR HOME

Termed "a shining example of what can be done with public money and private effort," a \$175,000 wing of the Astor home for emotionally

disturbed boys at Rhinebeck, N. Y., was dedicated last fall by high dignitaries of church and state. Raymond Houston, New York's commissioner of social welfare, pointed out that the state welfare and mental health departments "needed the help of private agencies to find out what emotionally disturbed children were and what could be done for them." Dr. Harvey Tompkins, director of the Reiss Mental Health Pavilion at St. Vincent's Hospital in New York City, asserted the new facilities were "a signal advance in child psychiatry."

The new wing includes four classrooms, seven therapeutic offices, quarters for nurses and case workers, and conference and observation rooms with one-way windows for teaching purposes, as well as a small gymnasium, playrooms, lockers, showers, and storage space.

Francis Cardinal Spellman, archbishop of New York, blessed the new pavilion. The Astor Home is administered by the Daughters of Charity of St. Vincent de Paul.

WOMEN APPOINTED TO RESEARCH POSTS

Named to "the first post of its kind ever established in the United States," Dr. Else Kris has joined the New York State Department of Mental Hygiene as research scientist in social psychiatry. In announcing her appointment, Dr. Paul Hoch, commissioner, pointed out that Dr. Kris has pioneered in combining psychiatry and sociology and is believed to be the only woman in the country to hold an M.A. in sociology as well as an M.D. In her new post Dr. Kris will conduct a comprehensive study of the social factors influencing the reintegration of mental patients after their release from institutions.

Dr. Lauretta Bender, of New York City, has been appointed principal research scientist in child psychiatry in the State Department of Mental Hygiene. The position was created under the department's new nine-point intensified treatment program which calls for greater emphasis on research in the emotional disorders of childhood and adolescence.

Dr. Bender will carry out research in the diagnosis, care, treatment, and follow through of mental illness, emotional disturbances, and anti-social or delinquent behavior in children and young adolescents in the state mental hospitals. Two wards at Creedmoor State Hospital, one for boys and the other for girls, will serve as the nucleus for this program.

Dr. Bender has been senior psychiatrist in charge of the Children's Service at Bellevue Hospital, New York City, for 21 years, and a member of the hospital staff since 1930. She will continue to serve as an attending psychiatrist on the children's service. She also will

continue as a professor of clinical psychiatry at the New York University-Bellevue Medical Center, a post she has held since 1951.

A well known research scientist, Dr. Bender has published over 100 papers on psychiatric studies of children conducted during her tenure at Bellevue. Last spring she received the Adolf Meyer Memorial Award for her multiple contributions to the understanding and treatment of schizophrenic children.

PROVIDE TRAINING IN CHILD PSYCHIATRY

Specialized training in child psychiatry is available in a number of member clinics of the American Association of Psychiatric Clinics for Children which have been approved as training centers. Training begins at the third-year, postgraduate level with minimum prerequisites of graduation from an approved medical school, an approved general or rotating internship, and a two-year residency in psychiatry, approved by the American Board of Psychiatry and Neurology. The majority of these clinics have also been approved individually by the American Board of Psychiatry and Neurology for a third year of training and for an additional year of experience.

This training is in preparation for specialization in child psychiatry, especially for positions in community clinics devoted wholly or in part to the out-patient treatment of children with psychiatric problems. At the completion of training, attractive openings are available in all parts of the country. Fellows receive instruction in therapeutic techniques with children in out-patient settings which utilize the integrated services of the psychiatric clinic team. Most of the clinics have a two-year training period although a few will consider giving one year of training in special cases.

Fellowship stipends are usually in line with U. S. Public Health Service standards—approximately \$3,600. Stipends sometimes are paid by state departments of mental health and by individual clinics, and occasionally communities pay for the training of psychiatrists engaged to work in these communities at the end of their training. Special arrangements may be made occasionally to supplement the stipends by taking on other responsibilities locally (part-time work with the Veterans Administration, consultation to social agencies, etc.). A limited number of training centers offer higher stipends.

The office of the American Association of Psychiatric Clinics for Children acts as a clearing house for applicants. Application may be made through this office or directly to the individual clinics. In all cases, acceptance of applicants for training is by the individual training centers.

For further information and for application forms, write to Miss Marion A. Wagner, administrative assistant, American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19, New York.

The Committee on Problems of Alcohol of the National Research Council annually makes grants for research projects, especially in biochemistry and physiology. Application forms may be secured from Jonathan O. Cole, M.D., National Research Council, 2101 Constitution Avenue, Washington 25, D. C.

DR. YAKOVLEV HONORED

The 1955 United Cerebral Palsy-Max Weinstein Award for outstanding scientific achievement in research on cerebral palsy has been awarded to Dr. Paul I. Yakovlev, clinical associate professor of neuropathology at Harvard Medical School. The award, which consists of a silver plaque and \$1,000, was given to Dr. Yakovlev for his fundamental studies in the anatomy and physiology of the human brain. His research will serve, it is said, as a guide for understanding the causes and nature of cerebral palsy and may lead to direct therapeutic applications. He was recently appointed curator of the Warren Anatomical Museum at Harvard Medical School.

UNITED STATES OBSERVES HUMAN RIGHTS DAY

By proclamation of President Dwight D. Eisenhower, Human Rights Day was observed in the United States on December 10, 1955. The celebration marked the seventh anniversary of the Universal Declaration of Human Rights, adopted without dissent by the UN on December 10, 1948.

In the words of its preamble, the Declaration raises "a common standard of achievement for all peoples and nations." The Declaration's moral impact has been reflected in 10 national constitutions, in judicial decisions, and in national legislation. President Eisenhower described it as "a significant beacon in the steady march towards achieving human rights and fundamental freedoms for all."

Human Rights Day is now observed by more than 80 nations.

DR. TOMPKINS HEADS COMMITTEE

Harvey J. Tompkins, M.D., of New York City, has been elected chairman of the professional advisory committee of the National Association for Mental Health. This group guides the organization on the psychiatric aspects of its program.

PUBLICATIONS OF INTEREST

Starting with the January 1956 issue, *Sociometry*, the first journal of inter-personal relations, will be the official journal of the American Sociological Society. Founded by J. L. Moreno in 1937, it pioneered in introducing sociometry, group psychotherapy, rôle-playing, sociodrama, and psychodrama into scientific literature.

The New York Academy of Sciences has reprinted as a monograph the article, "Psychotherapy and Counseling," by Lawrence K. Frank, Rollo May and 46 other researchers, which appeared in Volume 63, pages 319-432, of the *Annals*. In this publication, investigators from five professions—medicine, psychology, social work, the ministry, and counseling and guidance—describe their techniques and results, emphasizing the need for cooperative efforts if satisfactory results are to be obtained. The monograph has 108 pages, is illustrated, and is available from the New York Academy of Sciences, 2 East 63rd Street, New York 21, N. Y., for \$3.50.

In January 1956 the American Psychological Association will begin publishing a new monthly journal, *Contemporary Psychology: A Journal of Reviews*. Edwin G. Boring of Harvard University will edit the journal, with Adolph Manoil of Park College as film editor. Twenty-six consultants in the specialized fields of psychology will assist Dr. Boring.

Contemporary Psychology's aim is to provide critical reviews of books in the broad field of psychology and related sciences, thus providing comprehensive coverage of the psychological literature. Specialized book reviews formerly appearing in the APA journals *Psychological Bulletin*, *Journal of Applied Psychology*, *Journal of Abnormal and Social Psychology*, and *Journal of Consulting Psychology* will be concentrated in the new journal.

Subscriptions to *Contemporary Psychology* will be \$8.00 a year, foreign subscriptions \$8.50 a year, with single issues \$1.00 each. Address correspondence regarding subscriptions to American Psychological Association, 1333 Sixteenth Street, N.W., Washington 6, D. C., and correspondence with the editor to Dr. E. G. Boring, Memorial Hall, Harvard University, Cambridge 38, Mass.

The last 10 years have seen a tremendous increase in the instrumentalities of international communication and collaboration. On the commercial side there is air travel; on the governmental side there are the UN agencies. On the side of citizen collaboration the World Federation for Mental Health is doing a remarkable job under the leadership of Dr. J. R. Rees. On the professional side, nursing,

psychiatry, psychoanalysis, child psychiatry, group therapy, etc., have their international gatherings.

The problems of publishing a national one-language journal are greatly magnified in the international effort. The International Institute for Research on Problems of Alcohol is therefore to be congratulated for its courage in launching the *International Journal of Alcohol and Alcoholism* under the joint editorship of E. M. Jellinek and H. Pullar-Strecker. It is to come out three times a year. The first number uses English, French, German, Spanish, and Italian. In addition to original articles presented in one of the five languages and summarized in the others, it publishes a classified bibliography of the current literature. The new journal is published in Oxford, England, by Blackwell Scientific Publications.

SIGNIFICANT MEETINGS

The American Orthopsychiatric Association will hold its 33rd annual meeting at the Hotels Commodore and Roosevelt in New York City, on March 15, 16, and 17, 1956. In more than 60 papers representatives of the wide range of professional disciplines and settings in orthopsychiatry will present orthopsychiatric theory and practice in five broad fields: schools and mental health; in-patient and out-patient psychiatric treatment of children; adolescence and juvenile delinquency; psychiatric clinic management; and adult psychotherapy.

The American Orthopsychiatric Association, founded in 1924, is composed of psychiatrists, psychologists, psychiatric social workers, and members of allied fields, including education, anthropology, and sociology. Members come from all parts of the United States, Canada, and abroad. Exie E. Welsch, M.D., New York, N. Y., is president, and Luther E. Woodward, Ph.D., New York, is president-elect.

Inquiries about the program, reservations, exhibits, and other details of the annual meeting should be directed to Dr. Marion F. Langer, American Orthopsychiatric Association, 1790 Broadway, New York 19, N. Y.

YALE SCHEDULES SUMMER STUDIES OF ALCOHOLISM

The Yale Summer School of Alcohol Studies will hold its 14th annual session from July 1 to 26 inclusive. Applications must be submitted by April 15. Registration is open to teachers and school administrators, physicians, psychologists, clergymen and denominational workers, nurses, those in personnel work and in social and welfare work, public health, probation and parole, alcoholism education and therapy, law enforcement, and to other men and women

engaged professionally in activities in which a knowledge of the problems of alcohol would be helpful.

The curriculum is organized around a number of major topics: the origins, structure, and nature of social problems; theories in the development of personality; society and the problems of alcohol; drinking as a folkway; the chemistry and physiological action of alcohol; the psychological effects; theories concerning the nature and treatment of alcoholism and specific contemporary problems; and current activities and trends.

NAMH HOLDS FIFTH ANNUAL MEETING

More than 550 delegates from Mental Health Associations across the country attended the fifth annual meeting of the National Association for Mental Health in Indianapolis November 3 to 6, 1955. F. Barry Ryan, Jr., was reelected president, and Dr. Harold W. Elley was renamed chairman of the board of directors.

Dr. Marion E. Kenworthy was named first vice-president; Mrs. Henry Ittleson, second vice-president; Howard A. Wolf, first vice-chairman of the board; Charles Schlaifer, second vice-chairman; Henry C. Brunie, treasurer; Alan T. Schumacher, assistant treasurer; Brandon Barringer, secretary; and Richard P. Swigart, executive director.

In addition, five new officers were named: Frank C. Foose, Region I vice-president; Luther Alverson, Region II vice-president; Dr. Walter H. Baer, Region III vice-president; Mrs. Ernest R. Rector, Region IV vice-president; and Mrs. Mary Jeffries, Region V vice-president.

The committee on nation-wide activities and program development recommended that a chain of mental health information service centers be established by all Mental Health Associations. Their aim would be to help the mentally ill and their families locate the right place for treatment and help former patients with readjustment problems, and to serve as centers which would help local groups evaluate their community's mental health needs.

In a speech at the keynote luncheon Sidney Spector, director of the Interstate Clearing-House on Mental Health of the Council of State Governments, pointed out that state governments will have to do a greater and better job of caring for the mentally ill. At another session, three speakers discussed the respective roles of, and the necessity for cooperation among, the federal government, professional groups, and voluntary associations. They were Dr. Curtis Southard, chief of the Community Service Branch of the National Institute of Mental Health; David Slight, superintendent of mental health centers for the Illinois Department of Public Welfare; and Mr. Ryan.

At a luncheon meeting devoted to discussions of research Dr. John D. Benjamin, of the University of Colorado, described research methods and limiting factors; Dr. Elley reported on the kinds of research considered appropriate for NAMH; and Dr. George S. Stevenson, national and international consultant for NAMH, reported progress in the 17-project schizophrenia research program directed by the Supreme Council, 33°, Scottish Rite Freemasonry, Northern Masonic Jurisdiction, through the National Association for Mental Health.

At the annual banquet Governor George N. Craig of Indiana emphasized the importance of the mental health movement and of the unmet needs in the field. Though it is vital, he asserted, to serve well the needs of those in mental hospitals by giving them the best possible care and treatment, it is vital also to devote money and effort to research and training of personnel so that the mentally ill may be better served in the future.

Judge Luther W. Youngdahl of the U. S. District Court stressed the importance of the human element in efforts to help the mentally ill. In addition to the important physical requirements—good facilities, adequate treatment and care, and well-trained personnel—the mentally ill have great human needs that must be met, he said, if the sick are to achieve peace of mind, personal satisfaction, and a sense of worth. He stressed that respect for the individual is the keystone of a mental health program.

Panel discussions, workshops, and idea exchanges on fund-raising, public relations, and education, along with film previews and exhibits, rounded out the program.

APHA FORMS MENTAL HEALTH SECTION

At its 83rd annual meeting November 14 to 18, 1955, in Kansas City, Mo., the governing council of the American Public Health Association established a mental health section. Its officers are John D. Porterfield, M.D., chairman; Paul V. Lemkau, M.D., vice-chairman; and Rema Lapouse, M.D., secretary. The new section's council members include Dr. Ernest Gruenberg, Miss Ruth Simonson, Dr. Benjamin Passamanick, Miss Dorothea Dolan, and Dr. Morton Kramer.

The new section held two regular program sessions and a luncheon meeting addressed by Leonard M. Scheele, Surgeon General of the United States Public Health Service. Papers were presented on social drift of schizophrenia patients, the distribution of the elderly in the population, and their health and mental health problems. There were three papers on mental deficiency, one on its distribution in a county, one on the relationship between the hypothesis of foetal

wastage and mental deficiency, and a third on prematurity and its relationship to various neuropsychiatric conditions, including mental deficiency.

A full session of the public health nursing section of the APHA was devoted to a panel discussion of the role of the public health nurse in mental health.

The new section welcomes as members all who are interested in epidemiological and administrative problems in providing mental health services. Application blanks may be obtained from the American Public Health Association, 1790 Broadway, New York 19, N. Y.

Dr. Reginald M. Atwater, executive secretary of APHA said that discussions at the Kansas City meeting pointed up mental health and care of the chronically ill as major problems of the future which undoubtedly will be emphasized during the association's 84th annual meeting in Atlantic City, N. J., November 12 to 16, 1956.

Dr. Ira V. Hiscock, chairman of public health at Yale University, assumed the association's presidency at the close of the meeting. The new president-elect is Dr. John W. Knutson, chief of dental services of the U. S. Public Health Service and the first dentist to be elected to the position in the association's history.

REPRESENT NAMH AT INTERNATIONAL CONFERENCE

Mrs. Henry Ittleson, member of the board of the National Association for Mental Health and pioneer volunteer in the mental health field, and Dr. George S. Stevenson, national and international consultant to the National Association for Mental Health, attended the annual meeting of the World Federation for Mental Health in Istanbul, Turkey, August 21 to 30, 1955. The conference drew almost 250 delegates from 33 different countries, including about 60 from the United States.

With the theme, "Family Mental Health and the State," scientific papers emphasized mental health and education, the rearing of small children, abandoned children, life stress and cultural change, mental health of families in rural areas, delinquent children, the dynamics of family life, mental hygiene in the home, and problems created by sickness and disability. Discussion groups focused on education, religion, family relationships, medical practice, alcoholism, leadership, parent education, and films. Mrs. Ittleson presided at a session August 23 on the problems of abandoned children.

Dr. Margaret Mead and Dr. Otto Klineberg, both of the United States, were elected to the executive board, along with Dr. Cato Hambro, of Norway, and Irene Cheng, of Hong Kong. Dr. Niilo Maki, of Finland, is the Federation's new president; Dr. E. Eduardo

Krapf, of Argentina, is vice-president; Miss Mildred Seoville, of the United States, is treasurer; and Dr. Stevenson deputy treasurer.

The Federation will meet next in Berlin in mid-August 1956.

RECORD ATTENDANCE AT MENTAL HOSPITAL INSTITUTE

More than 400 attended the Seventh Mental Hospital Institute sponsored in Washington, D. C., October 3 to 6, 1955, by the American Psychiatric Association. Representatives came from all the 48 states and from Puerto Rico and Canada. About half were psychiatrists; 69 were hospital business administrators; and 89 came from other hospital disciplines and from related agencies.

In addition to holding eight work sessions, delegates visited St. Elizabeths Hospital, the clinical center of the National Institute of Mental Health at Bethesda, Md., and Chestnut Lodge, Rockville, Md., a private residential treatment center.

The theme was "Patient Participation in Treatment." Discussions focused on such topics as progressive responsibility and freedom for patients, staffing needs, and housing problems. The difficulty of obtaining sufficient mental hospital personnel and of providing them with adequate training was, delegates agreed, directly related to the matter of providing the conditions for patient-freedom. It was generally recognized that a hospital had the major burden for training its non-professional staff and that in-service training courses should be given a high priority.

The development of councils of patients, and the encouragement through them of self-government, seemed another means of moving toward freedom for patients and of providing an opportunity for the hospital staff and patients to work cooperatively on day-to-day problems met by both groups.

In discussing the contribution of the hospital's physical structure to the care of patients, Dr. Paul Haun, director of professional education for the Psychiatric Institute of the Pennsylvania Department of Welfare, asked: "May we agree that patient care, whether custodial or consciously therapeutic in aim, does not occur in a vacuum? And that between alternative physical environments we prefer for our patients the one which is safe, efficient, flexible, and attractive? May we also consider what contributions the physical structure of our hospitals can make to the efficiency, comfort, and self-esteem of our staffs?"

Dr. Jerome Frank of Johns Hopkins, Baltimore, lectured on group psychotherapy, and APA President R. Finley Gayle, Jr., spoke on the rôle of psychiatric units of general hospitals in the immediate care of the acutely ill.

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EDUCATION AND MENTAL DISEASE IN NEW YORK STATE

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THE frequency of mental disease varies throughout New York State in relation to the characteristic with which it is being correlated. For example, the incidence of mental disease varies with the degree of urbanization. Large cities generally have higher rates of first admissions to hospitals for mental disease than small cities, and both have higher rates than the rural populations.

Among the important characteristics of the population is that reflecting the spread of formal education. In New York State relatively few have had no formal education, more than half have attended elementary school, and a substantial number have been to high school and college. The question arises, therefore, as to whether the annual rates of first admissions to hospitals for mental disease in New York State vary in the several population groups in accordance with the degree of formal education. Prior to 1940, there were no data on the spread of education among the general population. The census of 1930 merely divided the population into two groups, the illiterate and the literate. On this basis, it was shown that illiterates in New York State had a higher rate of first admissions to hospitals for mental disease than literates.¹ This was attributed to a combination of constitutional and social factors. Thus, since school attendance at appropriate age-levels is mandatory for almost all in New York State, native-born illiterates were probably retarded intellectually in vary-

¹ Malzberg, Benjamin. "Literacy and Mental Disease." *Psychiatric Quarterly*, Vol. XIII, January, 1939, pp. 145-159.

ing degree. On the other hand, illiteracy among the foreign-born is more likely the result of social than individual factors, as, for example, the lack of earlier opportunities for education.

However, a grouping of the population into a class of "literate" is so broad that it conceals any important differences that may be related to the degree of education. Does the rate of first admissions vary according to the degree of education? Is there a continuum in such rates from those with no formal education to those with a college education?

The census of 1940 was the first to make such an analysis possible. In that year, a question on the census schedule asked for the last full grade that the person had completed, whether in public, private, or parochial school, college, or university.² Corresponding data were available for first admissions to all hospitals for mental disease in New York State during three fiscal years which began July 1, 1938 and ended June 30, 1941. Unfortunately, too many of the histories of the first admissions lacked information as to the highest grade completed. It was therefore necessary to group them in broad classes: no education, common (elementary) school, high school, college. It was also necessary to exclude that portion of the population which had not completed formal education and was still at school. This introduced the assumption that those aged 25 years or over had completed their formal education. The following analysis therefore is restricted to the white population of New York State aged 25 years or over on April 1, 1940, and the corresponding white first admissions to all hospitals for mental disease in New York State.

There were 35,748 first admissions to these hospitals during three years ended June 30, 1941. Of this total, 4,283 (12 percent) had no education; 21,341 (59.7 percent) had attended common school; 7,450 (20.8 percent) had been to high school; and 2,674 (7.4 percent) had been to college (including graduate schools). The corresponding percentages for the general population were 5.6, 53.9, 28.4, and 9.7. It is evident, therefore, that first admissions with no education and those with some degree of common school education reached higher

² See Sixteenth Census of the United States, 1940. Population Fourth Series. Characteristics by Age. New York, 1943, pp. 101-102.

percentages than the corresponding general population, and that first admissions with some degree of high school or college education had less than their expected quotas.

It may be noted in Table 1 that those with no education were in great relative excess among first admissions with psychoses with cerebral arteriosclerosis and with senile psychoses. They represented 20.2 and 23.9 percent, respectively, of the corresponding first admissions, whereas those with no education included only 5.6 percent of the general population. On the other hand, only 4.4 percent of the first admissions with manic-depressive psychoses had no education, and only 5.5 percent of the first admissions with dementia praecox fell into this category. First admissions with alcoholic psychoses were also relatively low in this category, with only 6.3 percent.

At the other extreme of the educational scale, though all first admissions included 20.8 percent with some degree of high school education, those with manic-depressive psychoses included 35.5 percent, which exceeded the corresponding percentage for the general population. First admissions with psychoses associated with advanced age had low percentages in the high school category. The same characteristic appeared in connection with the college group. Though 9.7 percent of the general population was in this category, first admissions with manic-depressive psychoses included 13.7 percent. The arteriosclerotic and senile psychoses were under-represented with 3.8 and 3.5 percent, respectively.

Our first conclusions, then, are: those with no education included 12.0 percent of the first admissions, which exceeded their quota by over 100 percent; those with some degree of elementary education were also in excess of their quota, but only by 11 percent. On the other hand, those with high school or college education reached only about 75 percent of their quotas. This leads to the conclusion that rates of first admissions are highest among those with no education and progressively lower among those with higher levels of education.

An important exception occurs, however, in connection with the manic-depressive psychoses. In this group, those with no education represented only 78 percent of their quota; this rose to 86 percent among those with an elementary education, to 125 percent for the high school group, to 141 percent for

TABLE 2. WHITE POPULATION OF NEW YORK STATE, AGED 25 YEARS OR OVER, ON APRIL 1, 1940, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION *

Degree of Education	Number			Percent		
	Males	Females	Total	Males	Females	Total
No school years completed	213,255	238,377	451,632	5.3	5.9	5.6
Common (grade) school	2,186,513	2,158,689	4,345,202	54.9	53.0	53.9
High school	1,036,785	1,253,103	2,289,888	26.0	30.8	28.4
College	451,497	333,776	785,273	11.3	8.2	9.7
Not reported	98,093	89,896	187,989	2.4	2.2	2.3
Total	3,986,143	4,073,841	8,059,984	100.0	100.0	100.0

* See reference 2.

the college group. In other words, increasing degrees of education were associated with increasing rates of first admissions with manic-depressive psychoses. These results will be delineated in greater detail in the following sections.

FIRST ADMISSIONS WITH NO EDUCATION

There were 4,283 first admissions with no education. They included 1,465 with psychoses with cerebral arteriosclerosis and 995 with senile psychoses. Together, these groups of

TABLE 3. WHITE FIRST ADMISSIONS AGED 25 YEARS OR OVER, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, WITH NO EDUCATION, CLASSIFIED ACCORDING TO MENTAL DISORDERS

Mental Disorders	Number			Percent			Average Annual Rate per 100,000 Corresponding Population		
	Males	Fe-		Males	Fe-		Males	Fe-	
		males	Total		males	Total		males	Total
General paresis	188	38	226	9.1	1.7	5.3	29.4	5.3	16.7
Alcoholic	132	28	160	6.4	1.3	3.7	20.6	3.9	11.8
With cerebral arterio-sclerosis	762	703	1,465	36.7	31.9	34.2	119.1	98.3	108.1
Senile	393	602	995	18.9	27.3	23.2	61.4	84.2	73.4
Involutional	107	331	438	5.2	15.0	10.2	16.7	46.3	32.3
Manic-depressive	36	86	122	1.7	3.9	2.8	5.6	12.0	9.0
Dementia praecox	178	214	392	8.6	9.7	9.2	27.8	29.9	28.9
Other	280	205	485	13.4	9.3	11.3	43.8	28.7	35.8
Total	2,076	2,207	4,283	100.0	100.0	100.0	324.4	308.6	316.1

psychoses included 57.4 percent of the total without formal education. No other groups of psychoses were of comparable numerical importance at this educational level.

FIRST ADMISSIONS WITH COMMON SCHOOL EDUCATION

There were 21,341 first admissions in this educational group. Of this total, first admissions with psychoses with cerebral arteriosclerosis were still the leading category, including 4,715

TABLE 4. WHITE FIRST ADMISSIONS, AGED 25 YEARS OR OVER, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, WITH COMMON SCHOOL EDUCATION, CLASSIFIED ACCORDING TO MENTAL DISORDERS

	Number			Percent			Average Annual Rate per 100,000 corre- sponding Population		
	Males	Fe- males	Total	Males	Fe- males	Total	Males	males	Total
<i>Mental Disorders</i>									
General paresis	1,082	360	1,442	9.4	3.6	6.8	16.5	5.6	11.1
Alcoholic	1,377	268	1,645	12.0	2.7	7.7	21.0	4.1	12.6
With cerebral arterio- sclerosis	2,638	2,077	4,715	23.1	21.0	22.1	40.2	32.1	36.2
Senile	1,157	1,457	2,614	10.1	14.7	12.2	17.6	22.5	20.1
Involuntional	518	1,153	1,671	4.5	11.6	7.8	7.9	17.8	12.8
Manic-depressive	435	842	1,277	3.8	8.5	6.0	6.6	13.0	9.8
Dementia praecox	2,050	2,044	4,094	17.9	20.6	19.2	31.3	31.6	31.4
Other	2,180	1,703	3,883	19.1	17.2	18.2	33.2	26.3	29.8
Total	11,437	9,904	21,341	100.0	100.0	100.0	174.4	152.9	163.7

(22.1 percent). This represents a marked relative decrease in comparison with those with no education, who included 34.2 percent of the corresponding total. The average annual rate of first admissions with such psychoses was 108.1 per 100,000 population among those with no education, but only 36.2 among those with common school education. There was a similar decline among those with senile psychoses. On the other hand, the manic-depressive group increased from 2.8 percent of the total with no education, and an average annual rate of 9.0 per 100,000 population, to 6.0 percent of the total with a common school education, and a rate of 9.8. A similar increase occurred among first admissions with dementia praecox. Their percentage of the total in each educational category increased from 9.2 to 19.2, and the average annual rates increased from 28.9 to 31.4 per 100,000 population.

FIRST ADMISSIONS WITH HIGH SCHOOL EDUCATION

There were 7,450 first admissions with some degree of high school education, corresponding to an average annual rate of 108.4 per 100,000 general population of similar education. The largest category was dementia praecox, which included 26.5 percent of the total in this group. This represents a continual increase, starting with those with no education. The average annual rate per 100,000 population rose to 28.7. The manic-depressive group increased to 13.1 percent of the total, and the average annual rate rose to 14.3. First admissions with psychoses with cerebral arteriosclerosis and senile psychoses decreased to 10.8 and 5.5 percent, respectively, of the total, and their average annual rates showed similar declines.

FIRST ADMISSIONS WITH COLLEGE EDUCATION

Dementia praecox, which was the outstanding category, included 24.2 percent of the total with some degree of college education. The average annual rate, 27.5, was almost the same as the corresponding rate for the high school group. In general, the average annual rates for the other groups of mental disorders did not differ significantly from those for the high school group.

These rates indicate the following trends. Rates of first admissions decreased from a maximum of 316.1 per 100,000 among those with no education to 163.7 among those with a common school education and to 108.4 among those with high school education. The rate for those with a college education did not differ significantly from that for the high school group. Rates of first admissions for general paresis, alcoholic psychoses, psychoses with cerebral arteriosclerosis, senile psychoses, and involutional psychoses all showed similar decreasing trends, the maxima occurring in the groups with no education. Dementia praecox did not show any trend, the average annual rate being 28.9 for those with no education, 28.7 for those with a high school education, and 27.5 for those with a college education. The trend for the manic-depressive psychoses was unique, however. The rate rose from 9.0 for those with no education to 14.3 for those with a high school education and to 16.0 among those with a college education.

TABLE 5. WHITE FIRST ADMISSIONS, AGED 25 YEARS OR OVER, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, WITH HIGH SCHOOL EDUCATION, CLASSIFIED ACCORDING TO MENTAL DISORDERS

<i>Mental Disorders</i>	<i>Number</i>			<i>Percent</i>			<i>Average Annual Rate per 100,000 corresponding Population</i>		
	<i>Fe-</i>			<i>Fe-</i>			<i>Fe-</i>		
	Males	males	Total	Males	males	Total	Males	males	Total
General paresis	300	98	398	8.9	2.4	5.3	9.6	2.6	5.8
Alcoholic	410	104	514	12.2	2.5	6.9	13.2	2.8	7.4
With cerebral arterio-sclerosis	374	430	804	11.1	10.5	10.8	12.0	11.4	11.7
Senile	134	276	410	4.0	6.7	5.5	4.3	7.3	6.0
Involuntional	134	360	494	4.0	8.8	6.6	4.3	9.6	7.2
Manic-depressive	249	730	979	7.4	17.8	13.1	8.0	19.4	14.3
Dementia praecox	849	1,122	1,971	25.3	27.4	26.5	27.3	29.8	28.7
Other	910	970	1,880	27.1	23.7	25.2	29.3	25.8	27.4
Total	3,360	4,090	7,450	100.0	100.0	100.0	108.0	108.8	108.4

These conclusions must be checked, however, against the fact that the several educational classes differ from one another with respect to age. Among the general population aged 25 years or over, those with no education had a median age of 54.4 years. Almost a third were 60 or over. This might have been anticipated in view of the fact that those with no

TABLE 6. WHITE FIRST ADMISSIONS, AGED 25 YEARS OR OVER, TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, WITH COLLEGE EDUCATION, CLASSIFIED ACCORDING TO MENTAL DISORDERS

<i>Mental Disorders</i>	<i>Number</i>			<i>Percent</i>			<i>Average Annual Rate per 100,000 corresponding Population</i>		
	<i>Fe-</i>			<i>Fe-</i>			<i>Fe-</i>		
	Males	males	Total	Males	males	Total	Males	males	Total
General paresis	47	13	60	2.9	1.2	2.2	3.4	1.3	2.5
Alcoholic	192	19	211	12.0	1.8	7.9	14.2	1.9	9.0
With cerebral arterio-sclerosis	162	113	275	10.1	10.5	10.3	12.0	11.3	11.7
Senile	61	85	146	3.8	7.9	5.4	4.5	8.4	6.2
Involuntional	76	81	157	4.7	7.6	5.9	5.6	8.1	6.7
Manic-depressive	177	200	377	11.0	18.7	14.1	13.1	20.0	16.0
Dementia praecox	373	275	648	23.3	25.7	24.2	27.5	27.4	27.5
Other	514	286	800	32.1	26.7	29.9	37.9	28.6	34.0
Total	1,602	1,072	2,674	100.0	100.0	100.0	118.3	107.1	113.5

education must have included a significant proportion of the foreign-born, who are generally older than the native-born, and a large proportion who must have been born during an earlier epoch, when attendance at school was not necessarily compulsory. Those with a common school education had a median age of 46.8 years, almost 8 years less than that of the population with no education. Only 21.4 percent were 60 or over. Those with a high school education were still younger, having a median age of 37.7 years. Less than 10 percent were 60 or over. The college group differed only slightly from those with a high school education. Their median age was 38.0 years, and they included 9.5 percent who were 60 years or over.³

Rates of first admissions are correlated with age, being highest among the older age groups. It is clear, then, that their age distribution would tend to raise the average rate of first admissions for the group with no education and to lower the rates for the groups with higher levels of education. Those with a common school education would tend to have an intermediate rate. It is therefore necessary to consider the average annual rates of first admissions in comparable age intervals. Such a comparison is appended in Table 7.

It is evident that the population with no education had higher rates of first admissions than the population at any other educational level. There was a progressive decrease as one passed from the level of no education to that of common school and then to high school. The latter, however, had lower rates than those with a college education, though the differences are not significant. Age adjusted (standardized) rates were as follows (see Table 15): no education, 254.8; common school, 155.7; high school, 124.7; college, 129.3. It is difficult to explain the difference between those of high school level and those of college level. Errors of reporting were possible, so that some first admissions with a high school education may have been misplaced in the college group. It is not probable, however, that such errors were significantly numerous to influence the rates. A generation or two ago, the social level of the body of college students was higher than that of the high school group. With the great broadening of

³ Computed from data in reference 2.

TABLE 7. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941,
CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College
25-29	164.0	140.4	78.1	78.7	233.2	111.2	85.6	72.1	202.4	125.1	82.2	75.9
30-34	223.4	134.3	91.6	94.2	120.9	116.8	90.1	86.5	163.4	125.4	91.6	90.9
35-39	217.7	138.1	95.4	92.3	190.2	122.0	96.0	101.0	207.0	130.1	95.4	95.9
40-44	184.0	136.7	99.4	116.0	176.5	112.4	95.8	112.3	181.7	124.9	99.4	114.4
45-49	195.6	128.5	108.0	138.4	171.9	123.5	111.0	110.9	182.7	126.2	108.0	126.8
50-54	213.7	144.8	122.6	161.5	210.0	137.9	119.9	107.4	211.8	141.6	122.6	139.0
55-59	243.5	160.8	120.9	148.7	220.2	136.3	112.2	101.4	231.8	149.1	120.9	128.6
60-64	281.8	199.7	137.6	173.0	300.6	163.6	123.9	116.2	291.3	181.8	137.6	148.2
65-69	395.0	251.3	215.5	225.0	394.6	194.7	205.4	196.3	394.8	222.1	215.5	212.0
70-74	620.7	344.0	235.7	205.9	572.5	274.2	218.5	248.4	595.3	307.1	235.7	225.4
75 or over ...	1,282.8	591.8	483.2	484.7	1,183.7	488.6	497.7	512.8	1,228.5	534.7	483.2	498.4

TABLE 8. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS WITH GENERAL PARALYSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation		Common		No Edu- cation		Common		No Edu- cation		Common	
	School	High	School	College	School	High	School	College	School	High	School	College
25-29	9.7	4.1	1.1	0.4	...	3.6	0.9	0.4	4.3	3.8	1.0	0.6
30-34	28.6	12.6	7.1	1.4	4.4	5.8	2.1	1.0	15.1	9.1	4.4	1.3
35-39	47.7	19.4	10.6	1.4	12.0	7.4	3.8	1.4	27.4	13.5	6.9	1.4
40-44	47.3	22.0	16.4	6.6	6.7	6.4	5.1	3.4	24.6	14.4	10.4	5.2
45-49	34.2	20.1	17.4	7.7	5.4	6.7	3.8	...	18.5	13.7	10.2	4.4
50-54	30.9	23.4	15.9	5.9	7.8	6.9	2.6	1.4	19.2	15.7	8.7	4.1
55-59	28.5	18.0	14.1	7.1	5.0	6.0	2.6	3.8	16.7	12.3	7.8	5.7
60-64	19.9	16.3	9.3	5.8	4.8	4.1	2.1	2.4	12.2	10.2	5.2	4.3
65-69	31.8	10.9	15.6	5.8	...	4.3	2.1	...	15.1	7.4	7.5	3.2
70-74	7.6	7.2	4.9	...	4.5	1.8	1.5	...	6.0	4.3	2.8	...
75 or over	16.4	5.1	3.1	12.0	2.3	1.7	...	...	8.7	3.2	1.1	6.1

TABLE 9. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation		High School		No Edu- cation		High School		No Edu- cation		High School	
	Common School	College	Common School	College	Common School	College	Common School	College	Common School	College	Common School	College
25-29 .....	...	2.4	7.9	2.8	...	1.9	1.8	0.9	...	1.9	4.7	2.2
30-34	28.6	7.1	17.0	9.0	...	3.5	2.3	2.9	12.6	5.6	9.5	5.6
35-39	15.9	20.9	23.6	18.2	4.8	2.0	4.6	2.9	9.6	13.2	14.2	9.9
40-44	21.9	20.9	24.8	20.0	4.0	0.8	4.9	5.1	11.9	12.6	15.1	12.0
45-49	25.6	17.7	28.6	18.8	5.4	...	4.2	4.9	14.6	10.2	17.0	11.4
50-54	30.9	26.8	26.8	26.0	11.2	5.6	6.4	2.9	21.0	18.0	17.3	13.0
55-59	23.4	21.2	24.5	19.2	1.0	...	6.0	3.2	12.2	12.3	15.7	10.4
60-64	14.9	23.2	21.8	14.9	1.2	...	6.0	5.7	8.0	13.0	13.9	9.2
65-69	16.7	23.4	18.2	11.4	1.5	...	3.1	1.0	8.8	12.8	10.4	6.2
70-74	10.1	4.9	5.2	4.9	2.3	...	1.8	1.5	6.0	2.7	3.4	2.8
75 or over ...	2.7	6.0	3.3	...	...	...	1.4	...	1.2	3.1	2.1	...

TABLE 10. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation		Common School		No Edu- cation		Common School		No Edu- cation		Common School	
				High School				High School				High School
40-44	...	1.4	0.5	...	1.3	0.8	0.2	...	0.7	1.1	0.4	...
45-49	8.5	2.9	2.0	...	6.3	3.7	2.3	4.2	7.3	3.3	2.2	1.8
50-54	45.0	19.1	10.2	8.9	33.7	13.2	8.7	4.2	39.3	16.3	9.4	7.0
55-59	90.7	49.3	30.1	26.9	89.9	38.7	22.7	21.0	90.3	44.2	26.0	24.4
60-64	167.6	98.3	64.4	63.4	183.5	81.3	48.7	51.9	175.7	89.9	55.4	58.4
65-69	261.1	154.9	127.9	96.4	238.2	111.1	100.8	67.7	249.1	132.3	111.8	83.5
70-74	360.8	199.9	175.1	137.3	248.9	144.4	119.9	150.2	301.8	170.5	141.0	143.2
75 or over	494.4	254.7	201.8	239.3	336.2	169.6	176.0	181.4	407.9	207.1	185.0	211.0

TABLE 11. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS WITH SENILE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation		Common School		No Edu- cation		Common School		No Edu- cation		Common School	
				High School				High School				High School
45-49	...	...	...	...	2.7	...	...	...	1.4	...	...	...
50-54	0.9	0.5	...	3.0	1.7	1.3	...	1.4	1.3	0.9	...	2.3
55-59	3.0	0.8	...	6.0	3.0	3.4	1.1	...	2.5	2.0	0.6	3.3
60-64	19.0	10.0	11.2	5.8	37.4	15.5	9.1	9.9	28.2	12.7	10.0	7.6
65-69	48.5	29.3	24.2	17.5	109.3	43.7	31.3	49.9	80.4	36.7	28.4	32.1
70-74	201.9	106.5	53.4	44.1	285.1	104.8	65.1	80.9	245.8	105.6	62.4	61.0
75 or over	730.7	310.9	251.5	215.4	829.2	304.9	313.4	325.2	784.6	307.6	291.7	269.1

TABLE 12. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS WITH INVOLUTIONAL PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College
35-39	3.2	0.4	0.2	3.8	4.8	2.2	1.1	2.7	4.1	1.3	0.7	3.4
40-44	6.8	5.0	4.1	3.6	51.9	20.0	11.5	9.2	32.0	12.4	8.0	5.9
45-49	33.1	10.4	7.6	21.5	70.7	41.9	28.5	29.6	53.6	25.4	18.7	24.9
50-54	28.3	20.1	16.8	19.8	90.8	48.8	37.7	22.3	59.8	33.6	28.1	20.9
55-59	27.5	20.0	19.2	11.3	70.7	31.8	32.2	26.8	49.2	25.6	26.3	17.9
60-64	8.7	11.6	15.9	11.5	36.2	17.5	18.1	12.4	22.6	14.5	17.2	11.9
65-69	3.3	9.0	12.8	...	7.6	6.6	10.8	10.7	5.6	7.7	11.6	4.8
70-74	7.6	1.6	...	...	2.3	2.1	4.6	...	4.8	1.9	2.8	...
75 or over ...	...	1.3	...	...	...	...	...	...	...	0.6	...	...

educational opportunities since 1920, however, it is probable that social differences between these two groups have tended to level off.

All the major groups of mental disorders, with the exception of the manic-depressive psychoses, showed the same inverse relation between the annual rates of first admissions and the level of education. (See Tables 8 to 14, inclusive.) The rates were highest for those with no formal education, lowest for those with a high school or college education, and intermediate for those with common school education. In general, the differences between the high school and college groups were not significant. An exception to this occurs in connection with general paresis, the rate for the high school population being in significant excess over that for the college group.

The manic-depressive psychoses furnished a notable exception to the trends for the other groups of mental disorders. There was a direct instead of an inverse relation between the level of education and the rate of first admissions. Among males, for example, the standardized rates increased progressively from 5.2 among those with no education to 6.5 among those with common school education to 7.9 among those with high school education to 13.7 among those with some degree of college education. Among females, the rate fell from 16.6 among those with no education to 13.8 among those with a common school education, but rose to over 18 among those with higher educational attainments.

The reverse is the case with dementia praecox, the highest standardized rates occurring in the group of lowest educational level and the lowest rates occurring at the highest educational levels.

We find, here, an almost direct parallel with the results of Faris and Dunham for Chicago.⁴ They showed that rates of first admissions varied directly with the distance from the business center of the city. Rates were highest in the center and decreased progressively as one approached the periphery of the city. The order of the rates was correlated with a variety of social factors indicative of varying degrees of social

⁴ Faris, Robert E. L. and H. Warren Dunham. *Mental Disorders in Urban Areas*. Chicago, University of Chicago Press, 1939.

MENTAL HYGIENE

TABLE 11. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASES IN NEW YORK STATE, 1939-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age (Years)	Males				Females				Total			
	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College
25-29		4.3	5.9	12.7	23.3	15.0	16.7	15.9	12.9	9.9	11.9	14.0
30-34	5.7	4.6	9.7	9.0	22.4	14.3	22.5	25.5	15.1	11.6	16.7	16.0
35-39	6.4	7.3	7.0	11.9	24.1	21.6	29.5	28.7	16.4	14.4	19.2	18.8
40-44	1.7	10.7	10.1	9.6	17.3	15.5	18.8	26.4	10.4	13.0	14.8	16.7
45-49	15.0	8.2	11.9	26.9	15.2	14.2	19.5	14.8	15.1	11.1	15.9	21.8
50-54	9.7	6.5	7.1	20.8	14.7	11.7	17.7	16.7	12.2	9.0	12.8	19.1
55-59	5.1	8.9	9.0	5.7	13.1	9.0	13.2	15.3	9.1	9.0	11.3	9.8
60-64	1.2	7.1	4.4	15.4	7.2	8.0	11.1	4.9	4.3	7.6	10.0	10.8
65-69		1.4	2.8	11.7	1.5	5.6	14.7	10.7	0.8	3.5	9.8	11.2
70-74	2.5	2.0	...	19.6	2.3	2.5	4.6	11.6	2.4	2.3	2.8	15.9
75 or over ..	...	1.3	...	...	...	0.3	1.7	...	...	0.8	1.1	...

TABLE 16. AVERAGE ANNUAL RATIO OF WHITE FIRST ADMISSIONS WITH DEMENTIA PRÆCOX TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1929-1941, CLASSIFIED ACCORDING TO DEGREE OF EDUCATION

Age Group	Males				Females				Total			
	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College	No Edu- cation	Common School	High School	College
25-29	48.3	62.4	69.6	47.9	100.9	54.1	47.0	30.7	61.4	69.6	48.1	42.4
30-34	27.4	42.7	40.9	44.1	53.7	57.4	25.1	34.5	72.9	60.4	37.7	41.7
35-39	92.1	51.3	28.2	24.7	77.0	54.1	35.6	32.1	63.6	54.0	32.2	27.7
40-44	27.3	36.5	17.2	14.9	57.3	36.7	25.2	24.4	55.1	36.6	21.4	23.0
45-49	43.8	21.6	4.3	20.4	40.3	24.9	20.3	19.0	41.9	28.2	14.7	20.0
50-54	71.0	14.4	7.1	9.9	24.8	19.3	13.6	25.1	24.9	16.7	10.6	16.2
55-59	18.3	13.7	7.1	7.1	16.2	14.6	13.7	9.6	17.2	12.5	10.7	4.1
60-64	12.4	6.7			15.7	6.9	4.9	2.4	14.1	5.7	2.6	1.1
65-69	2.7	2.7	1.4		6.1	3.1	9.4	7.1	4.3	2.9	7.4	3.2
70-74					9.1	1.4	1.6		4.8	0.9	0.9	
75 or over		1.3			...	2.6	...	...		1.9		

MENTAL HYGIENE

TABLE 15. AVERAGE ANNUAL STANDARDIZED RATES OF WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939-1941, PER 100,000 CORRESPONDING POPULATION CLASSIFIED ACCORDING TO MENTAL DISORDER AND DEGREE OF EDUCATION

Mental Disorders	Males				Females				Total			
	No Educa- tion	Common School	High School	College	No Educa- tion	Common School	High School	College	No Educa- tion	Common School	High School	College
General paresis*..	30.6±2.6	15.8±0.6	11.0±0.7	4.3±0.7	5.4±1.0	5.6±0.3	2.8±0.3	1.4±0.4	17.8±1.3	10.6±0.3	6.8±0.4	2.8±0.4
Alcoholic*	19.0±2.0	20.3±0.7	14.7±0.8	16.2±1.3	3.3±0.8	4.1±0.3	3.1±0.3	1.7±0.4	11.0±1.1	12.0±0.4	8.8±0.4	8.8±0.7
With cerebral ar- teriosclerosis† ..	126.5±5.2	68.8±1.2	51.5±1.5	46.8±2.2	106.9±4.5	50.9±1.0	40.3±1.2	39.0±2.3	121.3±3.5	62.2±0.8	48.3±1.0	45.3±1.6
Senile†	63.0±3.7	29.2±0.8	22.1±1.0	19.4±1.4	83.1±4.0	31.4±0.8	26.7±1.0	30.4±2.0	81.8±2.9	33.5±0.6	27.4±0.7	28.3±1.3
Involutional‡ ...	15.5±1.8	9.4±0.4	8.7±0.6	9.9±1.0	46.1±3.0	23.3±0.7	18.2±0.8	14.8±1.4	29.9±1.7	15.9±0.4	13.1±0.5	12.1±0.8
Manic-depressive ..	5.2±0.1	6.5±0.4	7.9±0.6	13.7±1.2	16.6±1.8	13.8±0.5	18.4±0.8	18.8±1.6	10.9±0.1	10.2±0.3	13.1±0.5	16.1±1.0
Dementia praecox*	48.6±3.2	36.7±0.9	20.4±0.9	21.6±1.4	49.9±3.1	35.3±0.9	24.8±0.9	24.2±1.8	49.4±2.2	36.1±0.6	22.7±0.7	22.7±0.4
All first admis- sions*	258.9±7.4	166.4±1.9	126.7±2.3	136.2±3.7	241.6±6.8	142.0±1.7	120.6±2.1	119.4±4.0	254.8±5.1	155.7±1.3	124.7±1.6	129.3±2.7

* Population of New York State aged 25 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.

† Population of New York State aged 45 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.

‡ Population of New York State aged 35 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.

disorganization. This was the picture for mental diseases as a whole. It was true for the major groups of mental disease, including dementia praecox. The one exception was the group of manic-depressive psychoses. Rates of first admissions for this disorder were distributed in a random order throughout the city, with a suggestion of higher rates in those sections of a higher cultural and economic level.

SUMMARY

It is evident that rates of first admissions to hospitals for mental disease vary with degree of education. In general, the rates are highest among the population which received no formal education. They were lower among those who received some degree of education in the common schools. They were still lower among those who attended high school. Those with some degree of college education had lower rates than those without education or with an elementary education only, but they did not differ significantly from the population with the educational level of the high school. It is difficult to explain this, since the older part of the college group must have belonged to a higher economic level. In any case, it is clear that there is a very sharp dichotomy between those with no education or education at an elementary level and those with higher degrees of education.

There is no reason for assuming that there is a direct relation between the amount of formal education and the relative frequency of mental disease. It is fairly clear that the relation must be an indirect one. Groups with little or no education are differentiated from the remainder of the population with respect to important social and economic characteristics. The primary factor is economic. Those with low income and low occupational status also have low educational status. Thus, both educational level and average rates of first admissions to hospitals for mental disease vary inversely with the economic level. To this, there is but one significant exception—the manic-depressive psychoses. It is possible that characteristics of personality leading to such disorders may be more prevalent, in general, among levels of society that are above the economic average.

A FOLLOW-UP OF A PSYCHIATRIC STUDY OF 57 ANTISOCIAL YOUNG CHILDREN

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AND SUZANNE TAETS VAN AMERONGEN, Ph.D., M.D.

INTRODUCTION

FOR many years students of crime have observed the considerable number of persons with a childhood history of antisocial behavior who persisted in the pattern of delinquent acting out to the point of criminal careers. Professor and Mrs. Sheldon Glueck¹ in the report of their recent survey of 500 delinquent boys found that over 50 percent of these boys had demonstrated symptoms of severe behavior disorder by the age of 8 and nearly 80 percent by the age of 11. Child psychiatrists studying adolescent delinquents have often traced the impulsive egocentric behavior back into the youth's early life. Dr. Douglas A. Thom, out of his long experience with children referred to a psychiatric clinic because of antisocial acts, came to the conclusion that aggressive and destructive young boys in their early-grade years constituted an important pool from which are recruited many later serious delinquent individuals.

Dr. Thom, therefore, in 1947 set up at the Thom Clinic (then the Habit Clinic for Child Guidance) a research project in pre- and early delinquency financed until June, 1952 by funds from the National Mental Health Act through the Commonwealth of Massachusetts. Young children from 6 to 10 years of age who were referred for aggressive destructive antisocial behavior by their parents or some community agency were to be studied primarily by the methods of child guidance treatment (that is, the child to be seen weekly by a child psychiatrist, the mother weekly by a social worker). The children were to undergo careful psychological testing, and thorough physical studies particularly of their neurological

¹ Glueck, Sheldon and Eleanor, *Unraveling Juvenile Delinquency*. Cambridge, Harvard University Press, 1950.

makeup were planned. Since Dr. Thom considered delinquency a complex human phenomenon, he hoped to include careful evaluations of the sociological factors impinging upon the lives of the young children and contributing to their antisocial patterns of living. Because of limited funds, the study became narrowed to the procedures which could be carried on within the clinic (that is, psychotherapy with the child and casework with the mothers). Psychological testing and physical studies were included on many of the cases but neither could be as inclusive as originally planned. Funds did not permit the collaboration of a sociologist or a criminologist.

The nature of the emotional disturbances within the families of these young children produced other limitations of the original plans. Many of the mothers refused to work with the social worker beyond a brief period and others maintained only an intermittent contact with the clinic at times of family crisis. Very few fathers agreed to come to the clinic for even a single interview with a staff member. However, in most instances the parents permitted their children to attend the psychiatric sessions regularly.

This project of delinquency research through clinical treatment had, despite changes in the original plans, several unique characteristics:

1. Fifty-seven children referred to a psychiatric clinic for aggressive, destructive, antisocial behavior were studied and treated by one experienced and skilled child psychiatrist, Dr. Kurt Rose.
2. This study dealt with antisocial children of the pre-teen years whereas most studies have pertained to adolescent delinquents.
3. Because the study was a research project, Dr. Rose did not work under the customary clinic pressures of waiting list, need for evidence of improvement relatively soon, etc. Even though certain of the children showed little change for a year or a year and a half, Dr. Rose could continue seeing them as long as he wished or until the parents withdrew their child.

4. Ten children were studied over two years and three of these for five years, unusually long periods of treatment and observation for such young children.
5. The children were seen on an ambulatory basis; with few exceptions they remained within their own homes so that the family interrelationships and influences were constantly in the picture.

Dr. Thom conceived of this research project as a study of the origin and early development of delinquent behavior; he also saw it as an opportunity to study psychiatric treatment of these young aggressive and destructive boys and girls. Clinicians who have worked with adolescent and adult delinquents have been constantly impressed with the difficulty of modifying the individual's impulsivity, his egocentric orientation, and his hostility to those around him. Dr. Thom postulated that the child of early grade school years should be more amenable to influence and change, that his character structure would be more flexible and his capacity to grow less atrophied. The second aim of the project then was to study whether these young children could be treated psychiatrically and how the treatment should be applied.

Description of 57 Children in Study

A statistical comparison between the 57 boys and girls comprising the research study and the children making up our 1953 total clinic caseload, which included aggressive and antisocial children as well as those with other disturbances, brought out the following interesting points:

1. The smaller percentage of girls among the 57.
2. The earlier ages at which parents ascribe the onset of disturbing symptoms in the 57.
3. The different distribution of religious affiliations in the two groups.
4. The smaller percentage of referrals made by parents in the antisocial group.

The list of major complaints leading to referral of the 57 antisocial children to our psychiatric clinic deserves consideration. In each instance, the child had repeatedly and persistently demonstrated such behavior as truancy, stealing,

firesetting, vicious attacks upon others, etc. Parents, teachers and others had applied various corrective measures which had had little or only transient effect upon the child's behavior. Many of these parents referred their children only after considerable community pressure and were obviously reluctant to work with the clinic once the child was in treatment. This finding, reported by many other professional workers, deserves special consideration in planning a program of treatment for early delinquent children and their families. These boys and girls—whatever their later history, with or without clinic treatment—were serious antisocial problems at an early age: their acts were not the occasional minor outbreaks common to the majority of children in their struggle for socialization.

Both Mrs. Glueck and we applied the Glueck Social Prediction Scales to the group of 57. According to these scales, 47 of the 57 children rated within the "high probability of later delinquency" scores.

It is important to emphasize that we are not dealing with a group of feeble-minded or dull children. Of those tested, only four fall into the low average range of intelligence, 20 are in the superior, and 27 in the average range. Despite their capacity, only 12 were doing well in school and 22 were barely passing. These facts underline the seriousness of their emotional difficulties, which interfere so clearly with their developing skills, acquiring knowledge, and learning to sublimate their energies.

Only eight suffered from serious physical disabilities. One child had a history of brain injury and another has had progressively more abnormal EEG tracings.

The broken homes emphasized by many workers are conspicuous here. Twenty out of the 57 do not live in the traditional family unit with both parents. Fourteen have a history of significant separations from the mother at an early age. It is striking that a study of these families shows that only nine can be considered a cohesive² family group, and

² "... evincing strong emotional ties among the members, joint interests, pride in their home, and a 'we' feeling in general." Glueck, Sheldon and Eleanor, *Unraveling Juvenile Delinquency*. Cambridge, Harvard University Press, 1950, p. 115.

only 31 show some elements of integrated family living. The contrast with the families of our total clinic caseload in 1953 is dramatic; there, 134 out of 221 families were described as cohesive family units, 70 with some elements of integration and only 16 as unintegrated.

Type of Contact with the Clinic and Results

1. Diagnostic study only	9
2. Treatment followed initial study	48
a. Duration of treatment	No. of children
5 years and over	3
4 to 5 years	2
3 to 4 years	2
2 to 3 years	3
1 to 2 years	16
Under 1 year	23
b. Status at time of termination of treatment contact with Dr. Rose (this status determined by present staff members as described below)	
Much improved	4
Improved	29
Unimproved	15

FOLLOW-UP STUDY

A. Methodology

On April 1, 1954 the Commonwealth of Massachusetts made available to the Thom Clinic funds to be expended by July 1, 1954 for a follow-up study of these 57 children. This study has been carried out under the supervision of the research section of the Thom Clinic, Dr. Rexford, chief; Dr. van Amerongen, senior psychiatrist, and Dr. Schleifer, chief psychologist. Our procedures for carrying out the follow-up study can be divided into two principal categories, namely, appraisal of the cases at the time Dr. Rose terminated contact with them and evaluation of follow-up data obtained during the April to July, 1954 period.

The appraisal of the case material in the records left by Dr. Kurt Rose, our psychiatrist, and Miss B. Stone, M. Hyde, R. Bernstein, and M. Shriver, successive social workers on the project, was carried out by present members of the psychiatric and psychological staff of the Thom Clinic under the supervision of the research section. Each person was as-

signed a group of cases to read and asked to fill out a form on each case, a copy of which will be found in Appendix I. Following the first reading, the staff members met to discuss problems which had arisen and to clarify points of definition as well as specific questions. Each staff member then read his group of cases a second time, making indicated changes in the schedules for each case.

Our designation of the status of the child at the end of contact requires special mention. Since Dr. Rose and the social workers who had worked on the project were no longer members of our staff and not available for work in this follow-up study, the psychiatrists and psychologists who read and evaluated the case records had no first-hand knowledge of the children and their families. Dr. Rose and his co-workers, however, had left detailed recordings so that evaluations of the most important points could be made by the persons reading the records.

The second set of procedures revolved about the follow-up information obtained largely by two experienced psychiatric social workers, Mrs. Helen Friedman and Mrs. Diana Waldfogel. These skilled caseworkers met weekly with Drs. Rexford and van Amerongen, first to plan the procedures and later to discuss the follow-up interviews. The 57 cases were divided between the two workers, with as much geographical grouping as possible. All cases were cleared through the Social Service Index to check for referrals to other clinics, social agencies, or hospitals and particularly to the Youth Service Board, Juvenile Court, and Society for the Prevention of Cruelty to Children. The workers then telephoned or wrote to the mother of each patient, explaining that we were interested in learning about the progress of her child since they last came to the clinic and asking to visit the home at a certain time. New addresses were traced through the Post Office and Police Directory, others were given by old neighbors if the families had moved.

A schedule was prepared (Appendix II) showing the broad areas we wished the caseworkers to cover in their interviews with the mother. Although the workers in their hour or hour and a half interviews kept these items in mind and occasionally directed the conversation to some point of particular interest

to us, the interviews were conducted with a minimum of direct question-and-answer technique. We are well aware from our clinical work of the shortcomings of data regarding emotionally charged topics obtained by questionnaire; we considered the information obtained by letting the mother take the lead in reporting what she wished about her child and his family, by observing her associations, rationalizations, projections, and so on more valid for our purposes. However, we had a helpful check on the presence of serious persistent delinquency from the Social Service Index, which indicates any contact with children's corrective agencies.

Because of time limitations, the workers were rarely able to visit when fathers were home but other relatives, the patient, and his siblings were frequently there. Permission was requested to consult his school regarding each child's educational progress and to obtain a report from any physician or agencies to whom the child was currently known.

Both workers discussed their cases with Dr. Rose to elicit any additional information he might have which was not recorded and to obtain data regarding the two children he continues to see regularly.

Total number of children in study.....	57
Total number of children followed-up.....	54
1. No information available (family moved).....	3
2. Data from other professional sources only (not advisable to see parents or they are not available for interview).....	9
3. Parents refusing interview.....	1
4. Number of mothers seen.....	44
5. Number of fathers seen with mothers.....	5

We were impressed that of the 45 mothers available who were approached for an interview, only one refused to see the social worker and she tempered her refusal by offering to be seen in the fall. Our follow-up workers were experienced people who requested the interviews and dealt skillfully with the mothers who were informed of the purpose of the visit when the appointment was made. It is true that some of them spoke frankly of their hostility to the clinic, social workers, or psychiatrist, others who had progressed considerably denied they had received anything helpful from the clinic, and others admitted specific criticisms while acknowledging the gains achieved at the clinic. However, when we recall that this is supervised

a group of mothers traditionally thought to be hostile and uncooperative and that many of these very mothers during our clinic contact made little progress or withdrew prematurely from their therapy, it was significant that the follow-up workers were generally cordially greeted and found terminating the interviews far more of a problem than getting the mothers to talk freely to them.

STANDARDS AND RATINGS

The 57 cases were divided logically into two groups: one of the nine children who were studied diagnostically, the other of 48 children who were seen for psychiatric treatment following diagnostic study.

When the case records of the 48 boys and girls were read prior to the follow-up interviews, each treatment case was rated as "much improved," "improved" or "unimproved" at the end of the contact with Dr. Rose. Our definitions of these ratings were as follows:

- A. "Much improved" indicated that there had been a cessation of aggressive or delinquent acts, that the child gave evidence of a substantial increase in tolerance of frustration and anxiety, that his egocentric and hostile orientation to the world had been modified as evidenced by improved relationships with adults and peers, and that he had made progress in the development of capacity to use his energies in socially accepted activities such as learning in school, work, hobbies, and recreation.
- B. "Improved" indicated that there had been a cessation of aggressive or delinquent acts, that the child gave evidence of some increase in tolerance of frustration and anxiety, and that there was some movement toward modification of his egocentric and hostile attitude toward the world. In few instances was there evidence of improved school performance, but reports of more satisfactory behavior in relation to the teacher and his classmates were common.
- C. "Unimproved" indicated the persistence of impulsive acting out of aggressive and antisocial behavior with little or no modification of intolerance for frustration

and anxiety and of the hostile orientation to the outside world and toward himself. Occasionally temporary progress was observed which broke down under the slightest stress, whether from within or without the child.

The follow-up data were analyzed and charted in six categories: (1) evidence of any delinquent behavior; (2) the child's progress in school; (3) his relationship to his peers; (4) his recreational and work interests; (5) his health, and (6) the present structure of his family. As we mentioned before, because the time available for actual interviewing was limited and because many of the mothers were preoccupied with certain aspects of their problems while giving little information regarding other items, we found that our data were incomplete for some of the children; these items were recorded as "no information" even when we might have inferred a more definite finding.

The principal focus of our inquiry was Chart I, Evidence of Delinquent Behavior:

- a. No evidence of delinquent behavior.
- b. Some suspicion.
- c. Petty (occasional truancy, pilfering, fighting other boys, etc.).
- d. Serious (repeated runaways, breaking and entering, etc.).

The three charts that follow give us information regarding the child's total pattern of development, how he has been able to turn his energies to constructive aims of learning, play, and work suitable for his age, sex, and social milieu, and whether he has been able to achieve social adaptations common to children his age. It is worth while to note that our evaluation of the child—both during his clinic contact and at the time of the follow-up study—was based upon our expectations for a well adjusted boy of his age and milieu.

Chart II. School Progress

Good—creditable school performance.

Fair—only passing work.

Poor—failing work or promotions not fixed on achievement.

No information.

Chart III. Relationship to Peers

Excellent—quality of relationships and number of friends appropriate to his age.

Adequate—relationships limited in number but adequate in quality.

Minimal—close contact with one or two persons on an immature level or infantile dependent level.

Poor — predominantly hostile.

Chart IV. Recreational and Work Interests

Suitable for age, sex, and milieu—appropriate range and quality for his age.

Fair—some interests and activities appropriate to his age.

Poor—severely limited or inadequate for his age.

No information.

Chart V, concerning the child's health, interested us both because pathology might increase his difficulties in adjusting and because he might express somatically unsolved emotional conflicts.

Good—no complaints or symptoms of illness; child functions well.

Significant disability—gross physical defect or illness.

Fair—general complaints about health but child is not handicapped.

Poor—poor health limits physical activity.

No information.

Chart VI, concerning family structure, enables us to compare the present family situation with that at the time of clinic referral. The meanings of these items are self-evident.

An initial diagnostic study was the preliminary step in our

evaluation and planning for each of the 57 children who made up this research project. In the case of the nine children who received only a diagnostic study, either the referring agency did not follow the recommendation for treatment, the family refused therapy, or we did not accept the child for therapeutic work. The three cases we could not follow up in any way were among these diagnostic studies.

FINDINGS IN DIAGNOSTIC GROUP

Each one of the diagnostic cases rated high probability on the Glueck Social Prediction Scales. Our follow-up information indicates that of the six children on whom we could obtain data, three are at present showing no evidence of delinquent behavior while three others are involved in serious antisocial acts. Four of the six are progressing poorly in school, but we do not know about their adjustment to their peers nor about their recreational interests. No specific information regarding their health was recorded. Three of the six families appeared adequately organized and two others poorly integrated, while one of the six children lives in a foster home.

SUMMARY OF FINDINGS ON THE 48 CHILDREN IN THE TREATMENT GROUP AT THE TIME OF THE FOLLOW-UP STUDY

Chart I. Delinquent acts

	MI	I	UI	T
No evidence	3	23	6	32
Some suspicion ....	..	2	3	5
Petty .....	..	2	2	4
Serious	1	1	4	6
No information ...	..	1	..	1
Total	4	29	15	48

Chart II. School work

	MI	I	UI	T
Good	3	6	1	10
Fair	1	12	2	15
Poor .....	..	8	11	19
No information ...	..	3	1	4
Total	4	29	15	48

Chart III. Recreational pursuits

	MI	I	UI	T
Suitable	3	5	2	10
Fair	1	7	4	12
Poor .....	..	7	6	13
No information ...	..	10	3	13
Total	4	29	15	48

Chart IV. Relationship to peers

	MI	I	UI	T
Excellent	1	4	..	5
Adequate	2	9	4	15
Minimal	1	12	4	17
Poor .....	..	3	6	9
No information ...	..	1	1	2
Total	4	29	15	48

Chart V. Health

	MI	I	UI	T
Good	4	13	4	21
Fair .....	..	2	3	5
Poor .....	..	3	1	4
No information ...	..	11	7	18
Total	4	29	15	48

Chart VI. Family Structure

	MI	I	UI	T
Well organized ....	..	4	..	4
Adequate .....	..	15	7	22
Minimal	4	1	..	5
Disintegrating ....	..	4	4	8
Placement .....	..	2	..	2
No information ...	..	3	4	7
Total	4	29	15	48

MI = much improved
I = improved
UI = unimproved

DISCUSSION OF FINDINGS IN TREATMENT GROUP

A. *Delinquent Acts*

It has interested us that not more than six of the 15 children considered unimproved at the termination of treatment have been involved in serious delinquent acts. All these children presented severe pathology when first seen at our clinic, ranging from psychosis, severe borderline states to psychopathic personality disorders. Although we have considered the possibility of an originally faulty diagnosis, our follow-up studies confirm our initial diagnosis of severe psycho-pathology. The fact that the severe delinquent symptoms did not persist raises various interesting questions. It is possible, of course, that our evaluation of the results of treatment at the time of termination was too pessimistic, perhaps because of faulty clinical judgment, perhaps because of the tendency of these families to present themselves to us at their very worst. We shall come back to this point when we discuss the status of the family from the follow-up study.

Only three of the improved group relapsed into delinquent activity and only one into serious delinquent activity. The latter case was one of the two girls in the study. Her parents re-applied for help at the clinic before the follow-up study, and she has been accepted for treatment.

One of the much improved group also relapsed into an incident of serious delinquent activity. From reports of the mother, who had been coming to the clinic off and on through the years, he seemed to have made great strides. He did well in school and had many friends. This boy, now 15 years old,

brings up an important aspect in our evaluation of treatment results and prognosis of this group of children. Like the 13-year-old girl in the improved group who relapsed into persistent serious delinquency, this boy illustrates that such children as the subjects of our study are particularly vulnerable to the stresses of adolescence and should be brought back into the clinic for support, if possible, even though prior treatment had worked out well.

Whereas a great deal of publicity is nowadays being given to the delinquent teenager, it is important to be alerted to the young child involved in persistent, aggressive, destructive, antisocial behavior. The period between the ages of 6 and 12 has many advantages for the treatment of delinquent children. These years in which the child is relatively freer from instinctual pressure provide an excellent opportunity to help him modify and strengthen ego defenses against his instinctual drives. There is no doubt that our 48 treatment cases offer convincing evidence that psychiatric treatment is able to bring about improved control and increased tolerance for frustration, leading to complete subsiding of delinquent behavior (in at least 32 of the 48 treatment cases).

On the other hand, the need for long continued contact with these children, particularly during puberty, seems to us imperative. Regular follow-up studies should be an integral part of any psychiatric treatment program for delinquents. A determined effort should be made to remain watchful of symptoms betraying an increase in emotional tension, often leading to delinquent acting out and warranting additional psychiatric treatment.

B. School Work

An important fact to bear in mind is that all these children had sufficient intellectual endowment for adequate scholastic performance. They ranged from low average to very superior intelligence. The majority of the unimproved group performed quite poorly in school, while the major mode of the improved group is fair. Compared to their adjustment prior to treatment, the improved group has maintained the same pattern of school functioning, while the unimproved group

shows signs of deteriorating school adjustment. It would seem this phenomenon has its roots in emotional defects. Though treatment helped these boys and girls give up patterns of delinquent acting out, the children did not mature sufficiently to achieve the school level of their peers.

C. Recreational Pursuits and Relationships to Peers

The children in the improved group had, in general, developed more adequate relations with peers since the end of treatment. However, many of the improved patients had both tenuous social relationships and recreational outlets at the time of the follow-up study. A smaller number were as restricted as the child found in the unimproved group. The ability to make and keep friends as well as find sources for sublimation is very much dependent upon the individual's capacity to give emotionally. Though we see the ability to control aggressive outbursts as a sign of increased capacity for instinctual control as well as increased tolerance for frustration, we note that the majority of these children still have serious problems of adaptation and are handicapped emotionally.

The follow-up study reveals another important element, namely, that our data made it very clear that we have as yet no conclusive psychiatric criteria to determine which child is suffering from relatively transitory delinquent symptoms and which is heading for a long criminal career. The question of what happens to the aggressive, destructive, antisocial behavior pattern in the course of treatment has concerned us, particularly when we consider the comparatively large number of children who at the time of the review study were suffering from physical symptoms for which no organic cause had been found. In several other instances, the description of the child's present life suggested strongly the development of a well-defined neurosis, replacing the delinquent pattern.

We mentioned in our introduction that no funds were available to carry out special physical studies at the Thom Clinic, but as with all clinic patients the children of this study who seemed in need of a physical check-up were referred to outside

clinics and physicians who could report back to us. For a large number of children direct health information at the time of follow-up is absent. Although we may assume that many mothers did not discuss this subject because the child was well, we have not incorporated such inferences in our statistical chart (Chart V).

D. Family Structure

An area that requires much more intensive study is the quality of the emotional interrelationship between these children and the other members of their family. We have been increasingly impressed by the severe pathology not only of the child himself, but of his parents as well. This pathology

COMPARATIVE CHART—FAMILY STRUCTURE

<i>At Termination of Treatment</i>					<i>At Time of the Follow-Up Study</i>				
	<i>MI</i>	<i>I</i>	<i>UI</i>	<i>Total</i>		<i>MI</i>	<i>I</i>	<i>UI</i>	<i>Total</i>
Well organized .. ..	..	..	..	..	Well organized .. ..	..	4	..	4
Adequate	2	18	..	15	Adequate .....	..	15	7	22
Minimal	2	7	6	15	Minimal	4	1	..	5
Disintegrating .. ..	..	6	6	12	Disintegrating .. ..	..	4	4	8
Placement .....	..	3	3	6	Placement .....	..	2	..	2
Unknown .....	..	..	..	..	Unknown .....	..	3	4	7
<i>Total</i>	<i>4</i>	<i>29</i>	<i>15</i>	<i>48</i>	<i>Total</i>	<i>4</i>	<i>29</i>	<i>15</i>	<i>48</i>

is especially resistive to treatment because of the intense unconscious gratification the parents receive from their child's delinquency. It has seemed to us that the resistance against giving up instinctual gratification for the sake of obtaining the satisfaction of being a respectable citizen is exceedingly great in this group of families.

We mentioned in our introduction how difficult it was in many instances to keep these mothers coming to the clinic. It was therefore very revealing to find that all but one were willing and that many were delighted to be visited by the follow-up worker. Our comparative chart shows that there is a very definite improvement in the overall status of these families, and we have been agreeably surprised to find that the follow-up study in many instances proved to contradict our previous pessimistic consideration. Many mothers who had

seemed to benefit very little from their clinic contact had made considerable strides and referred to their previous social worker and to Dr. Rose with a great deal of positive feeling. They declared that the clinic had not only helped them and their child but had promoted a completely new outlook on life, resulting often in an improved social and economic status for the whole family.

Summary

A review of the present status of 57 young children from 6 to 12 years of age studied and treated from 1947 to 1952 for persistent aggressive, destructive, antisocial behavior corroborated our initial hypothesis and clinical findings that such behavior is symptomatic of a severe character disturbance.

The follow-up study carried out in the spring of 1954 indicates that psychiatric treatment was effective in at least 32 of the 48 cases in curbing the patterns of delinquent acting out. Many of these children, however, are still deficient in their social relationships, perform below their intellectual capacity in school, and show little interest in constructive recreational activities. Several boys suffer from somatic symptoms for which no organic cause could be found.

Of the group of 15 considered unimproved after termination of clinic contact six have not continued delinquent behavior so far as we could detect. On the other hand, one girl belonging to the improved group and one boy of the much improved group relapsed into serious delinquency at the onset of puberty. The number of families of the children treated at the clinic who showed considerable improvement socially and economically was larger than we expected upon evaluation at the time of termination of clinic contact.

Conclusions

This treatment research project and its follow-up study have contributed greatly to our knowledge and understanding of the pre-delinquent child between the ages of 6 and 12. We see a need for further psychiatric research along three main lines of investigation:

1. Careful "microscopic" study of the emotional makeup of the antisocial child, through diagnostic psychiatric interviews and study of the intra-psychic changes taking place during the treatment period, complemented by physiological and psychological studies.
2. Investigation of the emotional interrelationships between the delinquent child and his environment, in particular the other members of his family, as well as a systematic study of the personality of both parents.
3. Testing of the effectiveness of different therapeutic approaches to those children and their family in promoting an optimal treatment result.

A joint effort of psychiatrists, psychiatric social workers, and psychologists might lead to more efficacious ways of reaching these children and their families before they get into serious trouble and of keeping them motivated to stay in therapy once their difficulties bring them to a psychiatric or social agency.

The persistent aggressive, destructive, antisocial young children constitute a pool from which an important group of future juvenile delinquents and adult criminals is drawn. They represent a group of highly disturbed boys and girls who in the vast majority of instances have suffered from severe emotional problems since a very early age.

Psychiatric treatment as carried out in the Thom Clinic in this study has proved to be effective in dealing with the antisocial patterns of such children. Therapy with these children requires not only highly developed special skills but a personality makeup enabling the therapist to function as a support and a desirable model for identification. Superficial measures such as recreational activities, although perhaps effective and helpful to the teenager who indulges in an occasional prank, are insufficient to curb the persistent antisocial behavior displayed by most children of our study. They suffer from a severe character disorder which rarely can be altered by environmental manipulation or disciplinary measures.

APPENDIX I

NAME	1. Sex M.... F
2. Race W.... N.... O.... ?....	3. Religion J... C... P... U...
4. Age of referral	b) Duration of symptoms:
	Under 6 mos.
	Over 6 mos.
5. Referred by: Parent	6. Study
School	Treatment
Other	
7. Type of symptom:	
Behavior, agg.	Learning
Behavior, passive	Delinquent
	Neurotic
8. I.Q.: Low	
Average	School progress: Good
Superior	Fair
V. superior	Poor
	Unknown
9. State serious physical disability:	
Past	Present
10. Socio-economic background:	
Lower, self-sup.	Upper
relief	Middle, upper
	lower
11. FAMILY	
a Broken home:	Separation:
	Divorce:
With whom child lives	
b Mother—history of separation from child	
Personality of mother c father	
Well adjusted .....	.....
Psychotic .....	.....
Borderline .....	.....
Neurotic .....	.....
Delinquent .....	.....
d Siblings number	In treatment (ever) Yes
	No
e Attitude of family toward clinic: Good .. Amb. .. Poor .. Unknown ..	
12. Relationship of parents to child:	
a Discipline mother father	
1. Unsuitable	1. Overstrict or erratic
2. Fair	2. Lax
3. Suitable	3. Firm but kindly
b Affection	
1. Indifferent	1. Indifferent
or hostile	or hostile
2. Warm including overprotec.	2. Warm including overprotec.

APPENDIX I—*Continued*

c Cohesiveness of whole family:

Unintegrated Some elements Cohesive

13. *On treatment cases* results: Much improved Impr. Unimpr.
 (if closed)

APPENDIX II

I. The Child

- a. Absence or presence of subsequent delinquent acts, character, and consequences
- b. School progress
- c. Social adjustment in and out of home
- d. Recreational interests, hobbies, etc.
- e. Job adjustment
- f. Health

II. The Parents

- a. Marital adjustment
- b. Social and economic status
- c. Emotional and physical health
- d. Attitudes toward patient and his study or treatment
- e. Evaluation of parents who have been treated at clinic

SOME LEARNING EXPERIENCES AS PSYCHIATRIC CONSULTANT IN THE SCHOOLS

I. N. BERLIN, M.D.*

EXPERIENCES over the past four years as psychiatric consultant in two school systems have slowly clarified my concepts of consultation in such a setting. The relation of these experiences to previously integrated attitudes learned in psychotherapeutic efforts with children and adults has also become clearer to me. It is my hope that by describing the highlights of the events of my own learning as a school psychiatric consultant some ideas might evolve that would both clarify my own thoughts and perhaps be of help to educators and those who work with them in a consultative capacity around child-parent-teacher problems.

My first experiences with school problems occurred during my period of training in child psychiatry by means of school-clinic conferences. These meetings concerned children in treatment in our clinic, where I was a member of the therapeutic team. Later, as a staff member and teacher of child psychiatry, I chaired such conferences involving school personnel and clinic staff members working with children and parents. I found that I carried into these conferences some of my previously slowly acquired understanding from work with parents and children, i.e., that often when parents talk about their children they are referring to aspects of their own personalities. They often will unconsciously mask anxieties about certain feelings and attitudes of their own by talking with concern about similar attitudes, feelings, or behavior in the child. Thus, in conferences with school administrators and teachers around problem children, I began to recognize how often the anxieties of school people were not only related to

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their concern about the disturbed child and how they might best understand him and help him, but also frequently to their anxieties about the kinds of feelings such a child engendered in teacher and principal. They often seemed concerned about how we or others would regard them if they were driven beyond their endurance and had to admit failure by excluding the child from school. I began to observe that when school people had the opportunity to share with us mutual experiences around a difficult child, and usually disturbed parents, they learned that we too were struggling to work with this family and had no easy answers. Then they seemed to relax and were able to express their feelings about the pressures they felt. As the school teachers and administrators began to feel that others understood and empathized with these feelings and were not disturbed or condemnatory at the possible exclusion of the child from school, there seemed to follow some relaxation of tensions and often plans were made to work with the child in the school setting. During these conferences little direct suggestion or advice seemed necessary.

With this background of experience I accepted a position as community agency consultant, which included work with a city and a county school system as well as consultation with the county health and probation departments. In this paper I shall describe my experiences with the two school systems.

The city school system operated a child welfare and attendance division under the long-time direction of a former school teacher with many years' experience in child welfare work. On her staff was a recently hired social worker. The school's psychological services consisted of a school psychologist, a former teacher who was also responsible for the program for the mentally retarded. A psychometrist administered intelligence tests and did occasional projective tests. These four people were eager for psychiatric consultation as an adjunct to their work, and formed a consultation team which worked together for four years.

At our first meetings with the whole group of school administrators and guidance people from the high schools we tried to clarify both what the group felt they wanted and what I felt I had to offer. Since we had no previous experience to help us decide, we finally agreed that a small group of the central

office staff would meet to draw up plans. We had no definite ideas of how best to work and only a clear awareness of the need to help school administrators and their teachers with the emotionally disturbed children who were an ever-increasing burden as the population of this area continued to mushroom.

Out of my experiences in the clinic, I had a vague idea that methods that had seemed helpful with one or two teachers and a principal might be equally effective on a much larger scale with all the principals. That is, my previous experiences had shown that reduction of tensions in administrators around specific problems seemed to make it possible for them to better help their teachers. I felt that if we could be of help to the administrators as a group with their anxieties and tensions around teacher-parent-pupil problems, they could and would be more helpful to their teachers, and their teachers, in turn, to the children.

My efforts to work regularly with a group much as I had worked with a few individuals around an acute, disturbing problem did not work out. However, such an idea is not easily laid to rest and I repeatedly returned to it with the usual unsuccessful results until I was finally convinced this was not an effective way for me to work. I must say that the consultation team showed unusual forbearance in permitting me further experimentation in this direction, despite their feelings from our previous experiences that we would again not be successful.

Thus, initially we arranged several meetings with the twenty-odd school principals and any assistants they wanted to bring along. At the same time, we arranged to meet in each of the high schools with the administrators, guidance person, and teachers around specific problems presented by disturbed children.

The first meeting with the administrators set the pattern for all subsequent meetings. The principals were somewhat tense and anxious about meeting with a psychiatrist, fearful that what they might say would be analyzed and that they would be exposed and found wanting in the presence of their peers. There was no spontaneity. To increase the comfort of the group, as well as my own, I would start each session with some discussion of children's problems with which I had

had experience. This was not enough. The group would have preferred formal lectures on child development, diagnosis of emotional disturbance, and specific or detailed directions about how these could be handled. When these were not forthcoming and the group was encouraged to bring case problems for discussion, they seemed to feel disappointed that nothing new was told them and that they received no real help. Some case problems were presented, but it became clear that each administrator was primarily interested in presenting the case of his current thorn in the side and receiving specific directions in handling the child. Most principals were not interested in listening to other case presentations or in joining in the discussion after each presentation from which some general inferences could be drawn. Staff problems, such as I naively hoped would be discussed, were never mentioned. After several such meetings there was common agreement that they were not very helpful, although some administrators expressed relief at discovering that the psychiatrist was human and even that he appeared to have no magic solution to their problems with difficult children.

The second phase of the first year's work centered around conferences in the three high schools on specific cases. In these conferences the consultant team of psychiatrist, director of welfare and attendance, director of psychological service, the welfare and attendance social worker, and the psychometrist met with the administrators, guidance director, and the several teachers concerned with each child.

Two of the high schools were old, well established schools whose staffs had been together for some time. The third high school had been recently built in an area densely populated by people of racial minorities who depended for their livelihood on seasonal work in agriculture and canneries. The staff of this school was newly organized and had just begun to function, and many of the teachers were new to the school system.

The attitudes in the established schools seemed to be: Here are our problems—you experts solve them for us. They wanted lectures from the consultant to the faculties and were for the most part disappointed that few problems seemed to be alleviated by the consultation and that no prescriptions and

ready solutions were forthcoming, and after several conferences in each of these schools they made it clear that the consultation was not of particular value to them.

In the new school there were many problems related to getting the school into operation. The administrative staff was eager to experiment and to find out what worked for them in many areas and accepted psychiatric consultation as a possible help in this period of flux. The superintendent and associate superintendent of schools both wisely believed that in the beginning the consultant service should be used where it was wanted and not forced upon anyone. Case conferences were initiated which included the administrative staff and those teachers working with the child who presented problems. Initially, teachers were reluctant to appear and talk to a psychiatrist. They seemed to fear that their deficiencies as people and teachers would be exposed in front of their administrators. When, despite their reluctance, teachers did come to the conferences and found that the psychiatrist and the consultant team did not analyze them, they expressed disappointment that the psychiatrist listened more than he talked. However, many teachers expressed relief that during these conferences they were able to discuss their feelings about what the administrator expected of them, especially the kinds of pressures they felt. The administrator was very much surprised at these feelings since he had often talked with the teachers about his recognition of the problems they were confronted with and his hope that they would not feel they had to have quiet rooms and be able to handle all their problems to be considered good teachers. The administrator's frank and receptive attitude greatly facilitated such discussions. It became evident that such distortions of administrative policy could best be dealt with in this fashion, with individual teachers around specific problems.

I gradually became aware of a repetitive phenomenon in the consultation. It was quite disconcerting at first to find that after the first meetings most teachers seemed disappointed and angry that the psychiatrist had not solved their problems for them. Later they seemed to express relief at having had the opportunity to talk with a receptive group about their difficulties with certain pupils. Thus, while they often loudly

proclaimed how little help they got, with few exceptions they were subsequently eager to return and discuss other problem children with the group. Slowly, more and more teachers expressed a desire to present their problems to the group. They seemed relieved that many of their feelings which they had believed were shameful—such as anger or hate, frustration, and the desire to quit and run away from a difficult situation—were often stated for them by the psychiatrist and accepted by the group as comprehensible human feelings. They began to feel that perhaps the presence of such feelings was not so shameful.

Other common feelings brought into the open were feelings that teachers must be fond of all pupils, that their goal was to have their pupils become fond of them, that they as teachers should never feel—and *positively* never show—anger or discouragement, and that the expression of such feelings would result in irreversible injury to the tender psyches of their pupils.

It was our practice that I not interview or examine the children about whom the staff was concerned. However, in one instance a Negro girl was such a severe behavior problem and so openly hostile and aggressive that her several teachers and the administrators asked me to interview the girl just this once, ostensibly to see if she were psychotic or potentially dangerous to others. I reluctantly agreed and talked with the girl for about forty minutes. I found, as I had expected, an insolently defiant blandness and complacency. After the interview, the consultation group met with the people concerned with this girl. I briefly outlined what I had found and stated that I felt I would have difficulty in working with her and reaching her, that I could certainly understand that such an adolescent might push her teachers to the point of giving up, and that perhaps the only solution might be to exclude her from school. One of the teachers heaved a big sigh and said, "Now you know what we've been up against. I just can't have her in my class." Several others agreed. Then one teacher said that at times the girl had gotten along in her class and that perhaps if her teachers would try her again and exclude her from class more promptly when she acted up, this might help. One by one each of the teachers related how

they thought they might better work with this girl and agreed to try again. We never heard again about this girl. The administrators reported six months later that she was adjusting passably well in all her classes and was no longer the source of such consternation to her teachers.

The administrative staff frequently made inquiries after the meetings and found that most teachers felt relieved, more relaxed and better able to work with their students, that from the conferences they seemed to get the idea that they could be more open and frank about expressing their feelings to their students, and that firmness rather than punitive or retaliatory hostility, which they felt when they were driven beyond their endurance, was not only *not* harmful but very helpful to their students.

After many months of such meetings, the relationship between the administrative staff and the consultation team became relaxed and easy. Under the leadership of the principal, the administrative staff began to discuss some of their difficulties in dealing with teachers who were hostile and aggressive and wanted to use physical chastisement as a solution to their problems with students, or teachers who were helpless and ineffectual and sent all their problems to the office for solution. They were also concerned with the teacher who was on tenure and was indifferent about her work. As these problems were discussed, differences within the administrative staff came to the fore. I used some of my learning experiences as an administrator on a children's ward to illustrate the problems and possible solutions which I found worked for me. The friendly relationship between the principal and his staff made it possible for them to express their feeling that he needed to be more firm and to expect more from certain teachers. After much discussion the principal agreed that this might be helpful to the teachers. From these meetings there was evident greater unification of the staff and greater freedom to explore differences.

This congenial high school staff provided excellent and essentially nontraumatic learning opportunities for me. Early I sensed the pressure from the group to have me express "expert" opinion on subjects in which I had no special competence. The temptation was often great to hold forth on

grading, on passing or failing students, on curriculum, etc., subjects about which I had only a layman's knowledge and the school staff had expert knowledge. I discovered that as I clarified for myself and the group (and with each subsequent group) the limits of my expertness and dealt only with the emotional problems of children, parents, and teachers, the school people were increasingly more aware of my respect for their competence and were more relaxed in consultation. I eventually learned that even to express an opinion as a layman about certain school matters was not a good idea, for despite any explanations on my part such lay opinions of mine seem to carry unwarranted weight. I finally learned to just tend to my own knitting.

From our work in this school, news began to leak out via the grapevine, at socials, and over the bridge table that psychiatric consultation was helpful to many teachers, and slowly from other schools came some requests for similar services.

At the end of the second year of consultation, it was decided that our time would be best spent with the elementary schools for the next year. The staff of this high school felt that they would like further regular consultation, but with the work of the past two years they could get along without regularly scheduled visits if they could avail themselves of occasional consultation as needed. This plan worked out very nicely and during the next two years only a few meetings were necessary.

The second, third, and fourth years of consultation were spent mostly with the primary schools, at first only with those where the administrators felt a need for consultation. Later an effort was made to spend some time with each elementary school so that the principals and a few teachers might find that the consultation team was composed of friendly and interested human beings with no particular omnipotence and no desire to "analyze" individual administrators or teachers.

As the team worked with more elementary schools, I suggested again that we attempt some meetings of principals with whom we had worked to determine whether they were now able to use group discussion of common problems as one means of helping themselves. The other members of the team,

recalling our previous unsatisfactory experiences in such meetings, were not enthusiastic about trying them again, but nevertheless scheduled them. Again we found that the administrators in a group felt pressure to discuss their problems but were reluctant to do so. On one occasion a fortuitous selection of the most verbal, secure, and outspoken principals came close to a free discussion of the administrators' problems. This was a group that least needed such help.

After several such meetings I finally agreed that our efforts should remain on the work with the individual principal and his staff. After another year of such work, we found that a few principals wanted to discuss some of their problems with teachers. We gradually evolved a plan in which the social worker of the team would visit the school one week prior to the meeting and get some idea of the cases to be discussed, help the principal understand the kind of information about the child's family which we found useful, arrange for psychological testing where the I.Q. of the child was in question, where projective testing might help, or where someone else's clinical opinion of the child seemed a good idea. He also began to suggest that the principal might reserve thirty to forty-five minutes of the consultation time to discuss any matters of concern to him about his teachers, if he felt it would be useful. Usually at the first meeting the principal did not avail himself of this opportunity, but sometimes during the second conference at his school he would spend a few minutes discussing some of his concerns about his faculty.

We found that in elementary schools, where teachers had a difficult child all day (in contrast to junior and senior high schools), the teachers' problems often seemed more acute.

The aggressive child and the child who thwarts the teacher's every effort to teach him subject matter by his indifference and apparent refusal to make any attempt to learn were most frequently brought to our consultation meetings. The aggressive child's open defiance, hostility, and restlessness seemed most anxiety-provoking to teachers. The child who was sullen, indifferent to learning, and passively defiant seemed to cause less anxiety but more frequently feelings of frustration and inadequacy in his teachers.

Most elementary teachers appear to feel an overwhelming

responsibility for their failure to reach such children and need to disguise their feelings of anger, hostility, frustration, and helplessness. When their best efforts at being understanding and kind do not alleviate the difficulties, the resulting feelings of disappointment, frustration, hopelessness, and anger are usually repressed as if they dare not feel them, else their colleagues and administrators would believe them to be failures as teachers. Not only do teachers feel they should not feel or express the anxiety, anger, and frustration engendered in them by such difficult children, but they feel that they must also suppress their anger at the administrator to whom they turn for help when he too seems unable to help resolve these problems.

It has become our practice to insist that the teacher, principal, and school nurse gather all possible information on the family history and early life of the child. We try then to sketch in a picture of the child's background and his relationships in the family to help us understand the child's present behavior and to help the teachers see the origins of the child's difficulties in his early relationships which antedate his schooling. Often this alone has given a teacher the sense that she was working with a child who had had long-standing problems which she could expect to modify only slightly and only over a long period of time. We would contrast this to the situational problems where the death of a parent, the father's unemployment, or acute family troubles resulted in emotional upset in a child. In these instances the teacher's sympathy and understanding are very important and frequently immediately helpful to the child.

When we discuss cases of very seriously disturbed children, I have frequently described my own experiences with such children: the difficulties they present in treatment and how long it usually takes to see any appreciable change even if one works not only with the child but with the parents as well. I stress that despite the best efforts of the clinic team we sometimes fail to modify the youngster's feelings about himself and the world around him. Usually the teacher and administrator feel less disturbed at the possibility of their failure to reach and help such a child. After such a discussion of possible failure, teachers are frequently better able to

work with the child. It seems to me that this is related to their relief that they need only be human teachers and administrators and that such failures need not reflect on their professional adequacy.

I have learned that my discussion and depiction of the kinds of feelings such children have aroused in me and other people who work with them is helpful. I cite from my own learning experiences that anger, hate, frustration, disappointment, and hopelessness are both human and universal feelings. I pointed out that as I could permit myself to experience these feelings with less anxiety and self-deprecation, and could communicate them to others, I felt more at ease with myself and it was less likely that these repressed feelings would erupt into overt or covert hostile retaliatory behavior with the child. I had found that expressing how I felt to the child, while not always necessary or helpful, was much less hurtful to him than the retaliatory withdrawal or punitive behavior which might otherwise break through. I had also learned that when one failed to verbalize such feelings to oneself or to others, the resulting internal pressures seriously hampered one's attentiveness, alertness, spontaneity, and ability to work without strain. Teachers seemed quite receptive to my discussion of my experiences in learning that to show such "forbidden" feelings with others—and if necessary with the child who arouses them—often eases tension and permits a more rational dealing with the problem.

Thus it has been the frequent experience of the consultation team that after discussion on my part the teachers seemed less involved with what they ought to and should feel with their pupils and could accept more easily the feelings in themselves that were actually there. During subsequent conferences some of them reported their increased success with difficult children as they became increasingly firm and refused to permit behavior which could not be tolerated in the classroom. One of the best classroom teachers we had met put it very succinctly: "The aggressive child seems to relax and trust me more when I don't put up with behavior that disturbs the class and me. I've learned through the years, to my surprise, that such behavior, when he gets away with it, also seems to disturb the pupil."

This teacher's experiences closely coincide with my own, and I have learned to stress the conviction of many of us who work with such disturbed children that they are often looking for an adult who can understand and tolerate the verbal expression of hostile *feelings* but who can and will prevent, or at least halt, the impulsive aggressive *behavior*. Teachers have related many times how distrustful such children seem to be of their efforts to be kind and accepting, and how much easier they become when they experience a fair and unswerving firmness. It often *seems* that such children are trying in part to force the teacher to react in the retaliatory hostile manner which they have experienced as a result of their behavior, and in part these children seem to hope unconsciously for a new, and as yet never experienced, interaction with the adult. Hostile retaliatory action on the part of the person working with a child usually means that person has abdicated the adult role and met the difficult child on his own terms, which is rarely helpful either to the child or to the adult. More and more teachers and administrators have reported that as they can rid themselves of their tense and anxious feelings by putting them into words, they have become less afraid that their anger would be expressed in either retaliatory behavior or uncomfortable anxiety about possible loss of control over their behavior. They have then experienced increased ability to handle these difficult children in the classroom.

The team early discovered that our emphasis on firmness and the prompt expression of feelings was taken by some teachers as license to express their feelings through physical chastisement. We have since emphasized repeatedly the difference between expressing one's feelings about what one might feel like doing and the actual carrying out of such feelings in action.

We also found that if we could help administrators to be more at ease about the hostile expressions of teachers toward them (when during a crisis the administrator did not seem to be very helpful), teacher tension was reduced. Those principals who at critical moments could say with equanimity something like "I'll bet you're angry with me because I don't seem to be of much help," found that often teachers then

could unburden their feelings of fury and sometimes despair. Frequently they could then return and work through the difficult situation with the feeling that their administrator really understood how they felt. Through our meetings some principals began to feel easier about their own fear of failure. During our four years of work, more and more administrators began to insist upon the parents' participation in working with the problem child instead of feeling they should be able to do this all alone.

During the last year of our consultation, the curriculum consultants have been able to participate more and more in our meetings and have subsequently indicated that they were able to use some of the attitudes and insights that resulted from such sessions to work more effectively with teachers.

On our return to an elementary school after a year's absence, the principal said, "Do you recall our last year's conference on Johnny, the scourge of our school? Well, the conference helped his teacher and me to handle his aggressive outbursts firmly and to anticipate them. You know, on the last day of school he walked up to me with a clenched fist and said, 'You wouldn't do anything to me today, would you?' I cautiously guessed I wouldn't. He then asked me to press his knuckle, and with some trepidation I did. His hand flew open and on the palm was written in ink, 'I love you.' " The principal had tears in her eyes as she related this. She mentioned that Johnny was far from being a model citizen, but he was getting along and beginning to do some school work.

At the beginning of the fourth year of school consultation, we met with a group of new teachers who were having difficulties with their classes. This experiment was approached with caution by our team because we had learned our lesson about the difficulties involved in such group sessions. We thought we would try this because these teachers all had similar, acute problems and anxieties and it seemed the only way to reach more than one teacher at a time during a period of need. The teachers were surprised to find that there were others in the same predicament and as troubled as they. Most of them, after some initial hesitation, talked freely about their difficulties. They all seemed bewildered that the pre-

cepts taught in education courses and fairly easily carried out in their practice teaching seemed so ineffectual in their overcrowded classrooms, with many tense, overactive, disinterested, and rebellious children, many from minority groups and many in marginal economic circumstances. The team's concern with these teachers, and the team's verbalization of the kinds of feelings these new teachers might have seemed to help them talk more freely. During the meeting several teachers began to express the feeling that perhaps they expected too much of themselves—maybe they didn't need to love all their pupils. They all seemed easier as the team related experiences from our work with other teachers. Members of the team gave examples to illustrate that as teachers were able to be more direct and firm and less afraid that setting limits in the classroom would be "traumatic" to their pupils, they felt better, the children felt better, and more learning in a more agreeable classroom atmosphere occurred. After this meeting we heard that several new teachers on the verge of resigning their positions took a new lease on life and most of the group felt more relaxed and better able to handle their classroom situation. In one instance where the situation grew increasingly difficult, we met with the teacher and her principal about a specific child some months later.

This service to new teachers, the opportunity, after four to six weeks of teaching to meet with the consultation team and discuss their mutual problems, will become a regular feature of the consultation program.

One of the most gratifying aspects of the consultation work has been the gradual development of the various team members in understanding and the ability to carry on the consultation methods individually. The increasing team-work, cohesiveness, and awareness were reflected in the increased ease and effectiveness of the consultation and the mutual satisfaction evident in each meeting as we strove to increase our effectiveness as a team.

The consultation program in this school system has been expanded from a total of three-quarters of a day a week to two days a week. The staff will be augmented by a psychiatrist trained in the same setting as the author, and by another full-time social worker and psychometrist.

CONSULTATION WITH A COUNTY SCHOOL SYSTEM

Consultation with a county school system was different only in that we did not work directly with the schools since they were mostly small and long distances from each other, and most principals also did some teaching so that conferences were difficult to arrange. Initially we tried to meet with all the staff of county consultants who advised the schools on curriculum matters. In this setting also, and for the previously mentioned reasons, such group meetings did not work out. We thus decided to meet with the guidance group consisting of the consultants in guidance, special education (i.e., program for the mentally retarded, home teachers, etc.), the part-time school psychologist, and the psychometrist, around problems presented to them by the various schools. Occasionally curriculum consultants, principals, and teachers joined the discussions. We also met every two months with the group of special teachers: the home teachers and teachers at the juvenile hall and the hospital.

In these meetings it became important to discriminate repeatedly between what might be therapeutic (i.e., helpful) and what could be called therapy (i.e., an explicit contract between two people for the specified purpose of working on the personality problems of one of them). These discussions helped to clarify both my relationship to the group and their relationship to teachers, consultants, and administrators with whom they worked. Similar clarification had been helpful in my work with the consultative team in the city school system.

In the county schools, too, the most disturbing child was the impulsive, hostile, aggressive, destructive child. As a result of consultation meetings team members began to work more with parents and to help school personnel include the parents in any efforts to understand and help a disturbed child.

It became clear that rarely were these children "totally rejected" by their parents. The more frequent picture was one of anxious overindulgence and passivity of one parent, the other parent being quite strict, demanding, and often punitive toward the child. Thus it appeared that in most instances the child was caught in conflicts between the parents out of which his behavior pattern resulted. Occasionally it was

found that the death of one parent or of both parents resulted in compensatory and indiscriminating overindulgence by the remaining parent or grandparents so that no limits were set for the child.

In our case discussions I had been tying in such impulsive aggressive behavior to early experiences of such children with their parents. These parents seemed to have particular personality problems which were recently described in the literature by Johnson and Szurek.^{1, 2}

Most investigators would agree that the parents' unanxious acceptance of their own feelings of whatever kind—sensual, sexual, childlike, sad, angry, etc.—would make it possible for them to nurture the infant, i.e., to easily fulfill all his wants, to gratify the needs of the growing child and clearly define for him acceptable and unacceptable behavior. Such parents could in each instance help the child who begins to act in an aggressively hostile or destructive way to find acceptable alternative activities. Thus the investigation and exploration necessary to growth and development would not be inhibited. This is especially so if the parents can help the child achieve a satisfying state of independence by helping him experience the pleasures which come from mastering the details of self-care as the child is ready to learn them. Such a child would thus learn from his parents that all his feelings can be both understood and expressed in non-destructive ways consonant with civilized behavior in the family and society.

The inability of parents to set limits on impulsive aggressive behavior often reflects both their anxiety about the eruption of such feelings of their own and the unconscious vicarious satisfaction they obtain when the child does something they would like to do but dare not. The parent who reacts to such impulsive aggressive behavior with harsh retaliatory measures and strictness in all phases of dealing with the child may see in the child a mocking caricature of his own attitudes and behavior which may be intolerable and enraging to

¹ See Johnson, Adelaide M. and S. A. Szurek, "The Genesis of Antisocial Acting Out in Children and Adults." *Psychoanalytic Quarterly*, 21:323-343, 1952.

² See Johnson, Adelaide M. and S. A. Szurek, "Etiology of Antisocial Behavior in Delinquents and Psychopaths." *Journal of the American Medical Association*, 154:814-817, March 6, 1954.

observe. It is probably true that behind both these attitudes of one or both parents is their unconscious longing for gratifications and satisfactions not realized in their own infancy and childhood which they unconsciously want the other mate to fulfill. The impossibility of such mutual fulfillment of childhood needs frequently leads to conflicts between parents and also makes it difficult for them to fulfill similar needs and demands of their children. Thus, often the child feels little incentive to behave in an acceptable way, since he has little gratification in his relationship with his troubled parents and is confused by their vacillation in setting limits on his behavior.

The meetings with the special teachers over the four-year period gradually became quite spontaneous. Most of the teachers could eventually discuss their own need to make up somehow for the failure of parents of sick, retarded, and delinquent children. They slowly recognized the unreality of their self-imposed burdens as well as how much energy such impossible expectations drained from them. This was all the more true since they were usually unsuccessful and felt inadequate as a result. Most members of the group began to accept the limitations imposed upon them by the child's pre-existing relationships, his physical and psychological handicaps, and the limited time they had with him. They also began to see as their primary job the teaching of the child. Paradoxically, it seemed, as these teachers expected less of the impossible from themselves, they began to expect more of the possible from their students. As they slowly felt less overidentified with the child and overly sympathetic with his handicaps, they seemed to be able to help the sick, retarded, or delinquent child more, with increased mutual satisfaction for student and teacher. Repeatedly, as teachers became more spontaneous in the group they talked of their oversolicitude for their students, their frequent exploitation by the students, and their feelings of being caught because as they tried to do more for their students, the students seemed to do less for themselves.

Over and over again these problems were discussed around specific cases. Here too the problem of the impulsive, aggressive child and the feelings he aroused were repeatedly

ventilated. The differences between authoritative and authoritarian attitudes of school teachers came up frequently as the teachers were able to reveal some of their own hostile and retaliatory feelings as they failed to help such children by sweetness and kindness. In the juvenile hall situations those teachers who were gradually able to be firm and just with delinquent youngsters, who could be quite honest and direct about the feelings these children aroused in them, reported their own greater ease, relief of tension, and decrease of punitive, retaliatory feelings. They simultaneously noted greater responsiveness from their pupils and less conflict about doing their school work.

The home teachers were concerned with their unique problem of working with the parents of these sick youngsters. They all resented the parents' overindulgence of the sick child, and often felt that parents subtly encouraged the child's invalidism and unnecessarily prolonged his stay in bed or at home. They felt that many parents were helpless in the face of the demands of the chronically ill child so that their job was much more difficult. Often such parents felt the teacher expected too much of their poor, sick child. These teachers were much concerned at the ease with which these youngsters avoided tantrums or threat of becoming ill. Teachers often felt impelled to tell parents they were not handling the child correctly and felt anxious at the amount of hostility this aroused in the parents.

As these situations were repeatedly discussed, the teacher's hostility toward the parents was ventilated. Discussions about the dynamics of the relationship between the parents and the chronically sick child occurred frequently. The ambivalent feelings of the parents toward the child, the parents' guilt about their desire to be rid of the burdens imposed by a sick child, the hostile and helpless feelings engendered by the child's demands were brought out and elaborated on by the teachers. Some teachers were able to see and verbalize parallels between the parents' emotions and their own. They could see the sequence of guilt about such "terrible" feelings and the resultant overindulgence and often abandonment of the role of parent or teacher, as if to deny the presence of

such feelings of resentment. Some of the home teachers discovered that if they tended to their job of teaching these youngsters and were firm in their expectations of what they knew the child could do, some parents seemed to learn from the teachers' attitudes.

A few of the home teachers also were able to express some understanding of the problems of the parents with the child. Parents would sometimes then turn to them for suggestions and seemed to be able to accept referral to the Family Service Agency or other agencies for help with their problems. Even in those families where the disturbed parent-child relationship continued without change, the teachers seemed to feel less tense and hostile with the parents and were able to work with the child somewhat more easily.

During the fourth year of consultation with the county schools, the psychiatrist previously referred to began to work with the entire consultant staff. Now, some three years after the initial efforts at such meetings had been abandoned, the consultant staff was freer and more receptive to such work and these meetings were more successful and looked forward to by many of the consultants.

Conclusion

In my learning experience I came to understand that the consultation process demands the same kind of self awareness on the part of the consultant as is necessary in the process of psychotherapy. Here too I began to develop some understanding of how long it might take before the team could feel that these efforts might appear fruitful. When I listened attentively to the discouragement of the various team members and occasionally expressed my own doubts that consultation in this form would prove helpful, there would usually be some shift in the tension and all of us would feel somewhat more optimistic. Early it is often disappointing to find that after a precise and, one even dares feel, a brilliant or eloquent discussion, little of what one has said seems to have been helpful and, moreover, it does not appear to have been remembered. Slowly one begins to recognize the impediments within the group to understanding and assimilating what is being said

The anxiety and tensions of the individuals, their own past experiences and present emotional and intellectual readiness, and the state of their relationship to the consultant and to the other people in the meeting are among the many factors that determine how much any one person will derive from any one meeting. One therefore begins to sense the need for continuing prolonged work together and for repeating some of the principles of working with people which is most easily accomplished around case discussions. As the consultant becomes progressively easier and more spontaneous in the group, and expects less of himself, more people seem to understand and utilize more readily what he has to contribute.

When the school staff eagerly turns to the consultant for his words of wisdom on matters of curriculum, grading, retention of pupils, etc., the temptation is often great to be the all-wise, all-knowing person that the staff seems to be looking for in the consultant. Yet, only by clearly defining one's own area of expertness can one be most helpful to the staff.

Although some in a group will be disappointed and disgruntled, an honest "I don't know" is reassuring to the administrators and teachers who both hope and fear that the consultant will pretend a superhuman omniscience. Such all-knowingness may be momentarily comforting to the anxious person, but it tends to make the staff feel even less competent and undermines their belief in their own abilities to handle situations, as they turn to the all-wise one to handle all their problems. Experienced school administrators have many times recounted experiences which bear this out, when early in their work they felt they did or should know all the answers and found their teachers becoming increasingly helpless and dependent on them.

The readiness of the consultant to admit his fallibility, to illustrate from his experiences his awareness of the kinds of feelings teachers and administrators might have in working with difficult children, and his acceptance of the possibility that they might fail and have to exclude a child from school as he has sometimes failed and given up in some therapeutic work seems to reassure the staff and facilitate freer discussion. As illustrated in this paper, often the readiness to accept failure has resulted in the staffs' feeling less self-critical and

pressed by the child, and subsequent efforts with the child have been somewhat more successful.

Initially, most of the staff working with the psychiatrist are apprehensive lest they reveal too many of their own problems. They fear being analyzed and having their privacy violated by the consultant. Only continued working together and repeated experiences in seeing that the consultant does not analyze them and their troubles is reassuring. At some point with each staff verbal clarification of the differences between what might be therapeutic (i.e., helpful), and the explicit agreement and permission to work together and explore problems, which is therapy, seems to clear the air of most of the residue of such feelings. This also seems to help the staff in understanding their role with other school personnel and reduces some of the anxiety attendant on such work. It also helps make clear to the staff that they need not feel impelled to somehow solve the teacher's personal problems, which one often senses as an uncomfortable burden among guidance staff and administrators.

It seems to me that the basis for my work as a consultant has been my ever-growing confidence in the integrative potential in human beings. Thus I became convinced that if I could be of some help in reducing the anxiety, tensions, and self-doubts of teachers and administrators, they could do their jobs better. I slowly learned that little, if any, direct advice on the handling of a problem was necessary or helpful. I found that I could not advise a teacher about how to teach better. I could only hope to help reduce some of her tensions which served as obstacles to her teaching, learning the techniques of teaching, or learning how to handle emotionally disturbed children in the classroom. In most instances where I felt impelled to give specific advice on the handling of a child, I later learned that the teacher felt burdened by it and could not use the advice in her work. When I spent the time indicating my awareness of the kinds of human feelings the teacher might have without pretending that I, a non-teacher, could understand fully the magnitude or details of the anxieties, this seemed to be more helpful. My illustrations from my own experiences of the difficulties I encountered in individual work with a similar child and what eventually seemed

to work with me also seemed to be of some help. I began to sense more quickly the moments when the teacher or administrator was ready to talk and the attentive silence of the consultation group seemed to encourage the expression and discussion of difficult and forbidden feelings with evident decrease in tension in the teachers involved.

I am certain that each consultant must find the ways in which he works most effectively. I hope that this recounting of my own learning experiences will encourage others to participate in the challenging, highly interesting, and enjoyable process that makes up psychiatric consultation in the schools.

THE PLACE OF THE MENTAL HYGIENE CLINIC IN A GROUP WORK AGENCY *

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DESPITE the title, this presentation does not attempt to define the place of a mental hygiene clinic in a group work agency because it is still too early to attempt to set up any fixed pattern. Not only do group work agencies differ in their programs, functions, and responsibilities as well as in the variety of their clientele—different age and sex groups, different ethnic-cultural groups, different social economic groups—but the organization and operations of the mental hygiene clinics differ in many ways.

Perhaps the first observation that may be made is that the mental hygiene clinic may be located or may periodically function in a group work agency primarily as a place where the necessary space, facilities, easy and simple access by clients may be provided. To this extent the group work agency provides a convenient place for the mental hygiene clinic, which may be conducted with little or no direct relevance to or participation in the group work agency except as it may receive and give priority to clients of the group work agency or members of their families. There may be considerable advantages in having a clinic thus located, since the group work agency may facilitate access to the clinic and reduce some of the resistance to the use of such a clinic, especially when clients or people in the neighborhood have confidence in the group work agency and will accept their suggestions and recommendations.

As we look back over the development of mental hygiene clinics from the early 1920's, there apparently has been a movement away from the conception of the clinic as a purely medical agency more or less aloof or isolated from the community, as were hospitals and clinics in those days, toward

* Presented at the New York State Welfare Conference, November 16, 1954.

an ever closer liaison with other community agencies. Thus, the child guidance clinics began to appear as part of the school system and to function under the school auspices primarily for school children. More recently, mental hygiene clinics have been established or reorganized as community clinics specifically and functionally related to other community agencies and programs, as, for example, in Kansas City, Mo.¹

It is probable that there will be more and more exploration and experimentation in this direction since we are still engaged in discovering in what ways mental hygiene clinics can be established and operated to provide increasingly favorable acceptance by people generally and to foster better communication between mental hygiene workers and other professional and occupational groups.

With increasing acceptance of the conception of mental health as the objective which assumes the need for larger and more effective facilities for diagnosis and treatment, but emphasizes the desirability of working through every possible channel to foster healthy personality development and maturation in every age group from infancy through old age, it seems clear that we can look forward to more social inventions oriented to these goals.

A mental hygiene clinic located in, or directly if not exclusively serving, a group work agency may perform a variety of functions other than diagnosis and therapy. It may have a place in a group work agency which very directly relates the clinic to all aspects of the program of the group work agency. Without attempting to give any kind of inclusive or exhaustive statement of this, we may attempt to examine some of these relations and functions.

When we think of the mental hygiene clinic as a resource for more than referral of cases for diagnosis and treatment, we envisage a relationship between the clinic staff and the group work staff that differs from the usual referrals. Here it should be remembered that the pattern for many years has been to refer a case to a mental hygiene clinic which then took over and usually carried on with little or no further com-

¹ Frankl, George. "Community Psychiatry and Its Organizational Problems." *MENTAL HYGIENE*, Vol. XXXV, No. 4, October 1951, pp. 532-59.

munications with the referring agency. Thus, a school may refer a child for diagnosis and treatment to a child guidance clinic, and neither the teacher nor the principal may have any further contact with that child or ever hear the outcome of his treatment by the clinic. This one-way pattern of communication is also found in group work and other agencies which refer individuals to mental hygiene clinics.

But more recently clinics have been recognizing that the school, the social agency, and other organizations usually have a very considerable knowledge of the individual referred for treatment which can be of considerable significance in both diagnosis and therapy. Indeed, more and more it is being found that, especially for children and adolescents, the clinic must involve not only the parents but the school and other agencies in any effective program of treatment and rehabilitation.

This has led to a reconsideration of clinical practice and a review of the long-accepted patterns of professional practice. It has involved a recognition on the part of the clinically trained, such as psychiatrists and clinical psychologists, of the importance, indeed the profound and crucial significance, of the social-cultural "field" out of which the client-patient comes and to which he must return, if he is not to be institutionalized. It is scarcely necessary to point out that this has created some difficulties insofar as it has necessitated an enlargement of the conception of personality problems as primarily—if not exclusively—intra-psychic conflicts. This issue between the now-classic conception of personality problems and the growing awareness of the personality as a dynamic process by which the individual relates himself to the world, to other people, and to himself, in and through the socially approved and traditionally prescribed patterns, is being debated in the professional journals and meetings.²

This somewhat prolonged digression is not, however, irrelevant to the topic we are considering because the readiness of a mental hygiene clinic to enter into and actively participate with the staff and program of a group work agency may turn

² Cf. Fairbairn, W. Ronald D. *An Object-Relations Theory of the Personality*. New York, Basic Books, 1954.

largely upon where the staff stands on this issue and how far they will recognize what has been called the psycho-cultural approach to mental health (to be discussed later).

While group work of any kind involves some kind of program in which a number of individuals participate concurrently as a group, nevertheless any group is composed of individuals, each an idiosyncratic personality with past experience and a repertory of highly individualized patterns of conduct and feelings. To the extent, therefore, that the group work program is concerned with these individuals and how they may be helped to cope with life more effectively as individuals through their group work experiences, the group work staff frequently find themselves handicapped, if not blocked, by an inability to understand specific individuals and to establish effective communication with them.

Today when almost every group includes individuals from a variety of ethnic-cultural backgrounds, with different traditions and varying capacity for recognizing and utilizing the English language, it is exceedingly difficult sometimes for a group work agency to operate with any degree of effectiveness with such diverse personalities. Moreover, in any group today there are liable to be one or more individuals who are disturbed personalities, either suffering from various neuroses or bordering on, if not actually, psychotic. Moreover, there are many individuals who are "difficult," either unable to join in a group process or finding a perverse satisfaction in blocking or sabotaging what others want to do.

If the group work staff can call upon the mental hygiene clinic to help them gain insight and understanding into these troublesome personalities, the effectiveness of their work may be greatly enhanced, but here we should note that the mental hygiene staff may initially find it difficult to respond to such requests for help in ways that are genuinely useful. If the clinic staff, as is usual, approaches individuals primarily in terms of making a diagnosis and reporting that diagnosis in the usual clinical terminology which they then communicate to the group work staff, the outcome may be somewhat less than desirable. Assuming that members of the group work staff have little or no clinical training or experience, they

may then accept the various diagnostic terms and begin to label individuals accordingly, or they may be more or less baffled and repelled by such language, which may give them little genuine help in how to deal with specific individuals. Unless the group work agency is intentionally concerned with group therapy (which ought not to be undertaken by someone without adequate clinical training and experience), such diagnostic categories and the usual clinical recommendations for treatment may be more or less irrelevant, when not disturbing, to the group work staff.

This situation has existed a long time in schools where the clinic staff has sent back reports on referrals in clinical terminology and has expected the school teacher to function clinically, despite her large and pressing responsibilities as a group worker in the sense of being a leader for a whole classroom of children. Teachers have often been disturbed by this, and they become resentful toward clinical workers and procedures which have not only failed to give them the kind of help they seek, but have expected them to undertake a new and difficult role for which they are often personally incapable and professionally unprepared. Therefore, this emphasis upon the difficulty of establishing effective communication between a clinical staff and a group work staff seems to be justified as indicating a potential source of difficulty which is being met effectively. However, this topic seems to be a significant aspect of our question of the place of a mental hygiene clinic in a group work agency and will serve to indicate the need for more experimentation in developing modes of two-way communication between these two staffs.

The group work staff will need some help and practice in learning how to formulate their questions to the clinical staff in terms which will evoke from the clinician the kind of insights and understandings that will enlarge the awareness and sharpen the perceptions of the group work staff so that as group workers, not as clinicians, they can carry on their group work programs more effectively. This involves a recognition of individual personalities and a way of interpreting their idiosyncratic activities so that the group worker can recognize not only the handicaps and limitations, but also the

potentialities, of each member of his group. Here the clinically trained staff member, accustomed to working in the person-to-person relationships of diagnosis and therapy, may at first find it difficult to discover just what from his clinical knowledge he can offer that will be useful in the group work program. Those clinicians who have some acquaintance with or have participated in group therapy are aware of the immense significance of the dynamics of the group and how this may be invoked for the benefit of the individuals composing the group. This involves a willingness and an ability to recognize both the manifest and the latent, or the overt and the implicit meanings, of individuals' activities and especially their verbal communications which are always accompanied by other expressions conveyed through tone of voice, facial expressions, gestures, and posture. An awareness of these can be appropriately cultivated by a group work staff with the assistance and guidance of a clinical staff without creating in the group workers a belief that they are competent to diagnose and to treat individuals or to utilize clinical terminology.

This may seem to elaborate what might be a fairly simple and direct relation between clinic and group work staff in terms of giving the latter the benefit of clinical knowledge without overloading its significance. But if we look forward to the increasing infusion of the mental health orientation into all our organized activities—schools, social agencies, and particularly group work agencies—it seems probable that some of these questions will have to be recognized explicitly and answered in terms of a collaborative endeavor on the part of clinic and group work staffs to develop some effective modes of communication and collaboration.

Whatever else the group work agency does, it is in a unique position to provide much-needed guidance, reassurance, and strengthening to an individual without the group's becoming aware of how much the staff is concerned about that individual for whom they are actively trying to provide such help. For children—and especially adolescents—this may be of great importance, since they may resist any direct proffer of help and resent being singled out for special attention.

However, it is possible, as Dr. Alexander Reid Martin³ showed years ago, to provide individuals with helpful service within the group activities insofar as the group leaders are given enough understanding of the individual's needs and potentialities, and some fairly definite suggestions for "treating" the individual within the group program.

This is not the place to elaborate on these procedures except perhaps to point out that presumably a group work agency operates on the assumption that every member of a group has potentialities for further development and maturation and for escaping from his often self-defeating patterns and feelings. Accordingly, we may say that the group work staff can benefit more from a statement that individuals need to realize their potentialities than from the usual clinical emphasis upon their defects and abnormalities. Indeed, it may be possible to distinguish between the clinical and the group work programs by saying that the clinic of necessity must be alert to the variety of often subtle, psychological personality disturbances and the weaknesses of the individual before it can try to build on the strengths of the individual. Social agencies, especially group work agencies, must work initially from strengths, seeking to discover and to evoke the individual's potentialities in a variety of ways. The assumption is that not only the group work leader, but that all the members of his group, need insightful guidance for providing the kinds of experience through which each individual can and will give up his customary patterns and replace them with new and more desirable patterns and relations.⁴

Being only too conscious of the complexity of the human personality and the many and subtle forms of resistance and defenses which they encounter in their treatment of individual personalities, members of the clinical staff are often very skeptical, if not opposed, to such procedures. Quite appropriately, they will point out the dangers involved in such a

³ Martin, Alexander Reid. "In-service Training of Recreational Personnel—A Contribution from Psychiatry." *Mental Health in Virginia*, Winter, 1954, and "Using Leisure-Time Agencies to Treat the Problems Confronting Adolescents." *American Journal of Psychiatry*, Vol. 109, No. 5, 1952, pp. 344-51.

⁴ Cf. Frank, Lawrence K. *How To Be a Modern Leader*. New York, Association Press, 1954.

practice on the part of those without clinical training, and emphasize that even in group therapy it may not be desirable or feasible to include certain individuals because they are unstable and liable to "blow up."

But this only re-emphasizes the importance of clarifying the aims and purposes and the nature of group work so as to delineate more clearly what can and should be undertaken to alert the group work staff to an early recognition of those deviant or aberrant personalities who should, if possible, be excluded from the group and referred for treatment.

In passing, it may be noted that an increasing number of clinicians who have been exclusively concerned with individual diagnosis and treatment and have been indifferent to or skeptical of what can be done in groups are recognizing group therapy and group work in mental health programs.

It may also be desirable here to clarify the meaning of group work as used in this discussion as distinguished from "group dynamics." In the now formally recognized group dynamics, the emphasis is upon the full and active participation of each member of the group in arriving at a consensus or group decision. This has been shown to be a highly effective procedure for action groups and for helping individuals to develop their often latent capacities for sharing in the leadership process and in learning to formulate their own opinions and, more importantly, to listen to others. However, not all group work is oriented to group decision. Despite the encouragement of every individual's participation in arriving at consensus, the aim is to focus and direct members of the group into a more or less "final common pathway."

Group work may, more appropriately, be directed, not to group decision and utilizing the processes of group dynamics for consensus, but rather to the reeducation, the maturation, and the development of individuals as individuals, utilizing the dynamics of the group for this purpose, guided so far as possible by clinical insights, understandings, and the positive suggestions based upon good clinical judgment. In these procedures, the uniqueness of the individual, his image of himself as a person, and his own idiosyncratic ideas and feelings are not only recognized and permitted expression, but are encouraged and strengthened, on the assumption that for living with

himself and others, the individual's potentialities should be recognized and developed and not subordinated to a group decision or consensus. To guard against any misunderstanding of this, it should be reiterated that for many purposes, the processes of group dynamics are essential but cannot be utilized as the exclusive method in group work without running the risk of making group work and adult education primarily action programs and fostering the increasingly strong pressures on individuals to fit into normative patterns which rob them of the opportunity of being unique individuals. If this distinction is valid and can be accepted, at least as a basis for further discussion and refinement, it is likely that communication and collaboration between clinic and group work staff may be facilitated because the group process in these terms becomes another method, like the clinical approach, for recognizing and helping individuals as individuals.

Again to guard against misunderstanding, this emphasis upon group work as a process of fostering the individuality of the members is not a plea for what is called *individualism*. Instead of provoking the person to assert himself in various ways that are usually disruptive and antagonistic to the group or social order, the purpose here being discussed is to help him to discover himself, to recognize and accept himself, and to believe in himself as he experiences such recognition and acceptance from the group members. Moreover, in the warm, accepting climate of the group he discovers himself saying what he did not realize he knew. He becomes, therefore, more of an individual, not a competitor in striving to outdo others in the most popular, common, depersonalized patterns. A person feels himself a member of the "lonely crowd" when he finds contiguity in place of intimacy, when he must conceal or deny his own unique self in order to be accepted, to belong, as we see so often in teen-age groups.

Here we may emphasize that our theories and social work educational program have largely been in terms of the relation of the individual to society or his group. We have little or no concept of the relation of society to the individual beyond the Rousseau idea of a social contract or Hobbes' notion of mutual self-restraint to avoid annihilation of all. We urgently need a concept that recognizes both the relation of the indi-

vidual to his society and of society to the individual, which in the writer's estimation calls for a circular dynamic transactional approach.

The great opportunity of group work is to provide occasions where the depersonalization of the crowd is replaced by membership in a group which the individual helps to create and maintain and in turn is responsive to, as we see in team play or in an orchestra. This means that all members of the group recognize that each one is a unique individual, to be accepted and responded to as such, so that each one thereby finds and gives recognition in a reciprocal, dynamic transactional process. This, of course, occurs only insofar as the leader evokes the individuality of each member of the group, who responds in ways that help establish the group and generate the dynamics of the group. Since these dynamics arise from his and the others' ways of relating themselves to each other and to the leader, we see how the individual members exhibit in the group what they rarely or ever can do alone or in an unorganized crowd. This, of course, involves expression of feelings which can be productive and generous, as shown in the group conversations which Dr. Rachel DuBois has developed for groups of strangers from different cultural backgrounds. Recalling the happy days of their childhood, they create a group climate in which each one contributes a euphoric reminiscence, unique but equivalent to those of others.

While this all may seem highly abstract and theoretical, it has very specific and immediate applications for the operation of a mental hygiene clinic in a group work agency. By making explicit some of the often unrecognized differences in assumptions and expectations, it may be possible to establish more effective means for the two staffs to work together in formulating their joint programs and to define more clearly what each can and should expect of each other, including in those expectations a readiness to learn from each other, particularly the difficult art of communicating in language which is meaningful to each other. This means that the group work staff needs orientation in what the clinic tries to do, and what are some of its basic theoretical assumptions and professional expectations, all of which can be provided if there is a genuine

willingness to recognize that the non-clinical individual does not need to traverse the whole range of professional education and clinical experience in order to gain some understanding of the way the clinic operates, how the clinician thinks, and what criteria he uses for evaluating individual personalities. Conversely, it may be said that the clinic staff, which frequently relies upon its superior position in the professional hierarchy and may therefore be less inclined to show the necessary humility in approaching another profession and trying to understand its knowledge, skills, and experience, needs more acquaintance with the group work agencies, what they are trying to do, and how they operate.

This puts a burden upon the clinic which may not be altogether welcome, but which it cannot ignore or evade. In many other cases, clinical staffs going into schools and colleges, industries, public administrative offices, and the like, are finding that they must undertake to understand what these organizations are doing, what are the problems and difficulties inherent in those organizations and their operation before the clinicians can become effective and make their services productive.

This process of mutual understanding is going on all over the country, and it is noteworthy that within recent years clinics are increasingly approaching group work agencies, either soliciting their help in meeting the community mental health needs or, in some cases, asking group work agencies to undertake the post-treatment rehabilitation of individual patients.

It may not be inappropriate to suggest that the mental hygiene clinic may function in a group work agency not only as we have been discussing, but also as a friendly and helpful critic-adviser of the group work agency and its staff. It is becoming clear that sometimes an excellent group work program is failing to attain its purpose and indeed may have to be terminated because one or more members of the group work staff are either incapable as personalities of assuming the roles of group work leaders, as those roles are now being delineated in more dynamic terms. Some of them are definitely unhappy, disturbed personalities who are using the groups to work out their own personality problems and needs

or as targets for expression of some of their chronic affective patterns. The mental hygiene clinic which is in close collaborative relations with a group work agency can be very helpful in discovering these personalities, especially those who may not be too clearly recognized by the non-clinical staff as potentially undesirable, if not hazardous, to the agency.

But here it should be remembered that our present-day understanding of vocational psychology is still rather limited and it may be possible that an individual who clinically might be highly questionable nevertheless in his functioning as a group work leader can and does operate effectively. Indeed, some of these somewhat unstable and aberrant personalities, as we are recognizing, may be very creative persons and because of their own life experiences may be quite sensitive to the needs and strivings of members of their group. The clinical staff in dealing with such an individual should be aware of these possibilities and hesitate before fastening any clinical diagnosis upon a person, however valid such diagnosis may be, without considering very carefully how well that individual is able within the group work process to perform adequately and productively.

Another service which may be rendered by the clinical agency is to help to understand the psychological and cultural equivalents that are exhibited by the clients of a group work agency who come from different ethnic, cultural, and religious backgrounds. Our judgment and our treatment of individuals is likely to be governed to a large extent by normative expectations of what any sane, normal, socially acceptable person should and should not do. Insofar as these norms, which we all cherish, are "culture-bound" and expressive of our own individual backgrounds and traditions, we may not be aware of how other patterns are essential equivalents because they seem so different, indeed bizarre, according to our norms.⁵ Thus, in many of our big cities we find children, adolescents, and families exhibiting various patterns of conduct and relationships which may be considered abnormal or expressive of criminal intent. But often these patterns are revealed to be a normal and usual practice long accepted and sanctioned

⁵ Martin, Alexander Reid. "A Study of Parental Attitudes and Their Influence upon Personality Development." *Education*, June, 1943.

in another cultural setting. Some very grave mistakes and profoundly unjust condemnations of individuals have been made by failure to recognize these diverse cultural traditions and the meaning and significance of these equivalent practices. This is important from the point of view of the group work process because a recognition of these equivalent practices and of the aspirations that are being expressed in and through them may be of immense significance for group work in its endeavor to evoke and build upon the strength of individuals.

Moreover, in group work, the development of a group as contrasted with a mere collection of isolated individuals often must wait upon the recognition and acceptance by these individuals of each other's diverse and sometimes conflicting patterns in action, emotional reactions, and similar manifestations of cultural patterns as idiosyncratic expressions of the individuals' traditions and family backgrounds. Just as the leader of the group must be able to accept differences, so each member of the group likewise must accept differences if they are to develop into an organized group in which the dynamics of the group can operate. In revealing these cultural equivalents and helping the group work staff to understand them, the mental hygiene clinic will need the assistance of anthropologists, sociologists, and social psychologists who can provide the information about these diverse patterns and help to interpret their meaning and significance in the larger cultural context wherein they have traditionally functioned. Moreover, these multidisciplinary teams are needed to discover what equivalents should be provided by the group work agency as a basis for individuals of different traditions to learn to think and work and play together. Here the experience of the 1920's in attempting to foster a rapid Americanization of recently arrived immigrants should be remembered because we now see that robbing people of their traditions and providing no adequate equivalents of the things people live by and for can bring a profound demoralization not only to that generation but to their children and grandchildren, as we are now realizing.

If we think of the mental hygiene clinic as based upon our enduring goal values—a belief in the worth of the individual personality and a profound conviction of human dignity—

and if we see the group work agency as having a similar set of aspirations, it should not be too difficult for the two professional groups to develop mutually agreeable and productive modes of communication and collaboration. But, as in all other situations of this kind, there must be a genuine respect for each other's professional competence and sincerity which does not have to be stated or defended, but may be taken for granted as the very basis of their relationship. In so far as the two kinds of professional workers can also accept as the criteria for planning their work together the primary importance of respecting and conserving the individual, and, so far as possible, enhancing his sense of his own worth and dignity as a person, then the two kinds of professional skills will reinforce each other and prove increasingly productive in their collaboration.

ATTITUDES OF RELATIVES OF LONG-HOSPITALIZED MENTAL PATIENTS REGARDING CONVALESCENT LEAVE

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THE change in philosophy from that of permanent custodial-type hospitalization for many mental patients to that of helping them pick up the threads of life back in the community is a chapter now being written at Spring Grove State Hospital in Baltimore. Only recently has it been accepted that persons should not remain in an institution unless it is impossible for them to live elsewhere, and through the years many patients have continued to live at Spring Grove State Hospital long after they could have taken up residence on the outside. Social workers have turned to this problem with the same zeal which characterized their work with chronically institutionalized persons caught in the rut of living for years either in antiquated county almshouses or outmoded institutions for the young, aged, or infirm.

Many long-hospitalized patients have been permitted to live out their lives quietly within the confines of the hospital in much the same way as other people live in the community. They work regularly each day, returning to their home building at night to eat, watch television, and go to bed as do thousands of people in the general population. They often have not mingled with the acutely ill mental patients for years but instead may live in a separate building on the edge of the hospital grounds in a manner similar to life in a working men's hotel. Others who are very elderly or physically handicapped may live a sedentary existence in a building having the appearance of an old people's home.

The question may well be asked, "If these patients could manage to live in the community, why have they remained in the hospital?" There are probably many factors which were pertinent. Perhaps until recently the rate of admissions to the hospital did not cause a problem of finding bed space for

the newly admitted severely ill patients. Or the increased interest in the treatment of mental illness following World War II brought new personnel with a fresh outlook. Again, the use of new drugs may have caused an acceleration of the present era of psychiatry in which the patient leaving the hospital is viewed not as cured but rather as having received maximum benefits from the facilities the hospital can offer him. Naturally the patient must also be judged not harmful to himself or others.

Certainly there were many patients not cured of their mental illness who left Spring Grove through the years and did not remain there as did the group with which this article deals. Many of those who left were simply removed from the hospital by their family or friends who took them back into a life in the community, protected or otherwise. Then what was the situation of the patients who remained in the hospital all these long years—some longer than half a century?

The group of patients hospitalized for approximately ten years or more, who were helped by the social service department of the Spring Grove State Hospital, furnish a variety of situations insofar as their relatives' attitudes are concerned. Some have relatives who were constantly supporting and encouraging them to leave the hospital, such as a brother of a patient who wrote:

I visited my brother, a patient at the hospital, on Sunday. During our conversation, he expressed a desire to be placed out on employment in some capacity for which he is qualified. If this could be arranged I would appreciate it very much. He informs me that some of the men are sent out on occasions and he would welcome an opportunity.

Since my domestic relations are not entirely satisfactory I do not believe it would be to the best interests of my brother to live with me at this time. Therefore, I would appreciate your efforts to have your social service department work with him toward finding a job and a place to live.

I would very deeply appreciate your interest and efforts in this matter.

To other relatives the thought of such a drastic change as the possibility of extended convalescent leave after so many years of hospitalization comes as a great shock. Often the relative, visualizing the patient's adjustment as no better than when first admitted to the hospital, feels confronted with the tremendous problem of assuming responsibility for the custody

of a seriously disturbed person. The old fears and memories rush to the fore: the relative is certain that the hospital, suddenly weary of its burden, is wishing to thrust the patient unceremoniously upon him for care and support.

It is readily understandable that many relatives, having rebuilt their lives in the community without the presence of the patient, face a major readjustment in renewing fully the family tie. Even though a relative may have realized that some time the patient would recover sufficiently from his illness to attempt to live outside again, it may be difficult to receive him. The wife of one patient had not seen him for several years although she had maintained some relationship with him by sending greeting cards and gifts from another state where she had gone nearly fifteen years earlier to reside with her relatives. When she was notified of the patient's pending release from the hospital, she responded:

I received your letter and it was a surprise to me because I have not heard from anyone how Mr. A. has been. I am pleased that he is better, but I do not know how he would be accepted in our old neighborhood, and to our son who soon will be in military service. As Mr. A. does not say how he feels, I do not know how the situation will be solved, but I would like to hear from you about any further plans.

Mr. A., the patient, feeling keenly his lack of ability to support his wife financially, was not able to write her until he was more certain of a warm reception from her. Therefore the social worker replied with an inquiry of whether Mrs. A. planned to visit the hospital or whether she preferred her husband to visit her. The wife then replied:

This is not an easy thing for me to write, but I feel that I cannot undertake the responsibility of Mr. A.'s release from the hospital. I do not think it is the right thing to do right now on account of our son who does not know his father at all, and who is just now starting out in life.

I have gone through difficulties such as I would not want him to come in contact with, at least not until he is much older. As I do not plan to visit the hospital I do not think it wise for Mr. A. to come here and thus raise his hopes too high. I have thought this over very carefully, and in view of circumstances all around, I believe I am doing the right thing.

Sometimes after having relinquished responsibility for the custody of the patient to the hospital for such a long period of time, the relative comes to view the patient as a permanent

charge of the institution.¹ Even though he may be legally responsible financially for the patient, he may not have assumed this responsibility except for occasional gifts. The relative then may become outraged at the hospital's move to approach him about his future intentions and he gathers his forces against such an encroachment. An illustration of this attitude occurred on the part of three sons who had never known their father except as a person confined to a mental hospital. An excerpt from the caseworker's initial interview with the sons gives a vivid picture of their reaction to their father's impending departure from the hospital after nearly forty years:

You could have cut the air with an icepick as I entered my office and met the glowering looks of the three sons and the wife of one of them! I sat at my desk and said that I hadn't met any of them yet although I had talked to Mr. Thomas B. to arrange this meeting today. They gave me their names in a surly fashion when I looked around the room inquiringly at each person in turn. I then asked for their addresses and telephone numbers because our hospital records did not contain these currently. They quickly gave me this information and then they all sat in stony silence looking at me.

I said I could readily see that they were feeling very angry at the hospital about the fact that their father could leave and I would like to hear what they had to tell me about this. The one who turned out to be the sole spokesman for the three sons spoke in a furious tone about how they had been told that their father could absolutely never get well. He looked at me defiantly as if asking me to prove the opposite. I told him that I had no question about the fact that their father had been thought to be incurable; the doctors believe even now that he can never be very much different than he is today and would not benefit from any special treatment here. The son said angrily that the hospital never has given his father any treatment anyway. I agreed that was probably true, except for medical care through the years. I added that perhaps the sons had some information about their father's behavior during his visits to their homes which led them to doubt whether he could manage to live outside? The son, still with great anger, said that for that matter his father never had been any trouble to anyone. Then what, I asked, was it they had to tell me?

Suddenly the floodgates broke open as the son burst out bitterly that his father had worked so hard all of his life in the hospital's industrial shop until his operation last year. The son's wife added heatedly that

¹ See Dayton, Neil A., M.D. and Clifton T. Perkins, M.D., "The Outcome of Mental Disorders," an unpublished study of findings in Massachusetts, for data leading to their conclusion that the longer the period of residence in the hospital, the greater the chance that the family will not be able to help.

it seemed as if the hospital was glad to keep him as long as he could work but now that he can't they want to throw him out. . . .

In the above interview, several incontrovertible factors stand out which are common in a group of long-hospitalized patients: that the patient was judged to be incurable years ago; that he was a faithful worker in the hospital for an extended period of time; and that the treatment he received by the physicians was predominantly general medical rather than psychiatric care.

The relative who has not kept in close contact with the patient during his hospitalization furnishes another type of situation. Kaplan and Wolf state: "Too often the family loses interest and the patient is lost on one of the chronic wards. Also, it is usually true that, because of shortage of personnel and the usual human frailties, the patient who gets the most consistent attention from his family also gets the most consistent attention from the staff."²

The sister of a patient who had not been in touch with him for some months, although she resided within easy traveling distance, presented a classical picture of a relative's feelings:

When I called you this morning, I didn't go into any details as I am on a party line. But I hope I made myself clear to you that my brother is worried. He said he didn't want to go into the outside world, that he is perfectly satisfied where he is. Now would he say a thing like that if he were well and able to meet responsibilities?

My brother has never had responsibilities. He always had my mother and father to shield him and take care of him, and now he is leaning on me and I am only too glad to do for him and advise him. Because I love him, he is my only brother.

See his trouble didn't start just a few years ago. He has been the same all his life. People walk all over him, he never has been able to take up for himself. Even as a child he would let other boys beat him up and come home crying. My mother sent him to a special training school for boys, he couldn't learn in classes with other children. So you see why he is better off there, not having any home to go to. Both our parents are dead.

I am afraid and he is too that he will be mistreated somewhere else. And as long as he feels this way, I will never consent to him leaving there unless I would be able to take him myself. Because I understand him.

² Kaplan, Arthur and Lois Wolf. "The Role of the Family in Relation to the Institutionalized Mental Patient." *MENTAL HYGIENE*, Vol. 38, No. 4, October 1954, pp. 637-8.

And now he is more contented than he ever has been in his life. He works in the flowers and raises a few vegetables and cleans his room and floors. But nobody pushes him. And I give him a little spending money and clothes.

So please don't worry him any more. I don't want him dissatisfied. It is also a worry on me and my health is not good. There are plenty of other men out there who would be glad to be out. So please let him know you won't worry him unless he is ready for it. I will appreciate your cooperation in this matter.

The shame of mental illness, the fearfulness, and the conflict between not being able to care for the patient herself and yet not letting herself permit someone else to do so who is perhaps less depersonalized than the hospital—all are vividly evident in the sister's letter.

The examples presented in this paper of the reactions of relatives of long-hospitalized mental patients indicate a need for an overall approach to the problem. There are serious emotional consequences for the relative when the lifetime plan of institutionalization of the patient is interrupted because the relative and the patient had each settled down to his respective role in the "institutionalitis"³ pattern ascribed to them in years past. Then too the very fact of long-term institutionalization heightens the importance to the patient of his relationship to his family. Kaplan and Wolf contend that "there is a peculiar situation of anonymity arising from the institutionalization of the mental patient. We are not negating the importance of interpersonal relationships within the hospital walls, but we are contending that the patient's interpersonal relationships with his family are of special importance. The hospital, as such, is lifted from the main stream of life and, for the patient who will recover, it is only a transition between a past and a future in the community. Therefore, no matter how successful the interpersonal relationships of the patient within the hospital, it is his link with the outside world that must be strengthened. The family embodies the 'normal' world of interpersonal relationships for the patient to which we hope to help him return."⁴ Litten states: "Certainly no one can doubt the value, if it is at all

³ For a thorough discussion of institutionalitis, see "Institutionalitis" by Lillian L. Cole. *Mental Hospitals*, Vol. 6, No. 2, February 1955, pp. 16-17.

⁴ Kaplan and Wolf, *op. cit.*, p. 639.

possible, for each patient to renew his relations with the world at large by beginning with the unit of his own family." ⁵

The changeover of mental hospital programs from custodial care to skilled psychiatric treatment has resulted in a by-product for the relative which cannot be met wholly through the individual approach. A halfway house, ⁶ operated by the hospital, would enable the relative to observe the patient move gradually into the community while still surrounded and protected by a medical structure. Perhaps other solutions are also indicated. Mental health education for the general public has not provided educational measures to aid the relatives of long-hospitalized patients. The challenge is plain.

⁵ Litten, Kathleen. "Evaluation of the Role of Social Service in Psychosurgery," *Proceedings of the 3rd Research Conference on Psychosurgery*, New York, 1951. Public Health Service Publication No. 221, p. 23.

⁶ Reik, Louis E., M.D. "The Halfway House." *MENTAL HYGIENE*, Vol. 37, No. 4, October 1953, pp. 615-18.

A PROGRAM IN SCHOOL PSYCHOLOGY *

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ALL psychologists place great emphasis upon the importance of the pre-school period in the development of the child because of the great variety of relationships and activities which are introduced during these early years. The child learns the nature of reality and its emotional tone, the meaning of restriction, and a differential understanding of mother and father. Perhaps because these experiences represent many "firsts," they seem to stay with the individual and influence a lifetime of motivations and decisions. We have in these early days the beginnings of personality formation which will continue to change and adjust as the individual meets each new situation. An emotional framework is constructed of these early experiences to house and categorize future ones.

When a child enters school, his first experiences are still in a state of flux and adjustment. They have not yet been fully evaluated and integrated. Most certainly they have not been shaped well enough to form the firm structure of the personality as it is to emerge later. To meet the ever-expanding demands of school life, the child is encouraged, and at times pressured, into formulating a more clearly defined, consistent personality. For all children this experience represents a period of stress.

The school represents for the child his first really formal extra-familial social organization. His family life, with its flexibility and variability, is the only formal social group he has previously known. The school has its laws, its leaders, its prestige structure, and its socially acceptable techniques of satisfying needs and reducing tensions. The child enters into this society with uncertainty sometimes bordering on panic.

* This program was prepared under the sponsorship of School District 15, Lawrence, Long Island, N. Y.

He makes this adjustment with the help and support of his parents and teachers but basically he must solve and adjust to this new social plan alone. The social and behavioral demands of the situation force him to establish what he is and what he is not. He begins to play a role in his relationships with other children, with his teachers, and with his concept of work. His behavior patterns will be derived from his previous experiences, his present relationships, and his expectations as to what his future role will be. This crystallization of the fairly diffuse needs of the child into the more condensed ones that the school requires results in the development of an enduring personality structure. Because the school introduces the child to the idea of working and playing in a formalized social setting more closely resembling future behavior than does pre-school activity, the school experience assumes a position second to none in the development of the happy and productive adult.

To meet their responsibility fully, educators must integrate the concepts of good mental health with those of sound intellectual development. The newer concepts of positive mental health have not yet, however, been substantially integrated into the educational system. Perhaps because most of the productive concepts in the mental health area have been derived from the increased study and understanding of the abnormal individual, there has been reticence in utilizing these findings in a classroom of normal children. Furthermore, much of our mental health knowledge has never been clearly stated in positive terms. Rather, emphasis is placed on what might result if the wrong technique were used. If parents and teachers are told only what not to do and little is really understood about what should be done, confusion usually occurs in the practice of the principle. It is far safer to ignore negatively presented ideas and even deny their usefulness than to get involved in something which is only partially understood.

The educator's principal difficulty in understanding psychological concepts results from the inadequacy of the translation of ideas as they are derived from the psychological clinic and adapted to the classroom method. What may be intelligible and useful to a clinician often appears vague and abstract

when it is directly applied in the classroom. Many of these psychological concepts may have been well-known and utilized in fields allied to education and even in the theory of education, yet excluded from the public school teaching method. Therefore, it is a prime function of the school psychologist to integrate this large body of psychological knowledge with the activities and techniques of the educational system. And this ability to adapt, interpret, and translate concepts requires a person as broad in training, experience, and interest as is his task.

In the past, the school psychologist was trained as a specialist in testing. His work centered about the placement and evaluation of children in school. As the horizons of psychology broadened, especially in the field of interpersonal relations, it seemed apparent that the role of the school psychologist would broaden also. The school psychologist of today brings with him not only the skills of psychometrics but, in addition, an understanding of and an ability to apply broader concepts: the effect of attitudes on learning, a more thorough understanding of motivation, the factors affecting interpersonal tensions.

Traditionally, education has meant the acquisition of knowledge, but experience has altered this view to include the wider objective of happiness and productivity in which intellectuality is only a part. With the help of the school psychologist, specific educational techniques assume the broader objective of integrating intellectual and emotional development. In this way, the school sets an example of positive mental health practices for the community to follow, and plays a more dominant role in the ever-important program of the prevention of mental illness.

Society has become alarmed at the extent of wide emotional disorders as indicated by Selective Service figures, increasing commitments to state hospitals, results of the White House Conference on Children and Youth, and sweeping juvenile delinquency. At the present time, mental health associations throughout the country are distributing much valuable educational material in the form of books, pamphlets, and motion pictures to parent-teacher organizations and citizens' groups. This attempt to change people's attitudes through purely intellectual material often has little effect because it fails to

influence or change the deeper emotional attitudes that are the roots of our behavior. The school, however, in its close relationships with parents and community has the potential, through actual contacts, to reach people on an emotional level and thereby greatly influence the present concepts of mental health.

The school psychologist must work with every member of the school staff to help promote these concepts. Each person—administrator, teacher, and school board member—has a special contribution to make and each has responsibility to the team.

FUNCTIONS OF THE SCHOOL PSYCHOLOGIST

The school psychologist has three principal areas of responsibility:

- I. Prevention.
- II. Testing and Counseling.
- III. Psychometric Group Testing.

I. Prevention

The prevention of emotional disturbance in the child is unquestionably the most important function of the school psychologist to consider because it offers the greatest hope for the future. Few school psychology programs can keep up with the demands made upon them. Each year, though the school psychologist's staff may be able to accomplish more as a result of adding personnel and better systematizing functions, there continually arise new problems to which a contribution may be made. A program of prevention is the only kind which will lead to a leveling off of this ever-increasing demand for psychological assistance.

A. Prevention begins with the school staff's awareness of psychological concepts in its approach to classroom problems. One way to accomplish this is to work with teachers in groups and individually. The psychologist conducts study groups in which general problems of child development and the specific application of this material to the classroom is discussed. The study group can be organized as part of an in-service training program. It is to be hoped that these courses would continue over the years so that all the teachers of the district might participate and benefit from this training.

B. Individual conferences between the psychologist and teachers aid the teachers in establishing a method of working with children who have particular educational needs. In this way, the teacher develops effective procedures for recording and studying case histories. She learns what aspects of the situation to emphasize in her work with the child.

C. The psychologist should develop lines of communication between guidance directors, school nurses, physicians, and remedial reading and speech teachers. Standardized techniques of communication and referral are established so as to facilitate control over the multiple activities of the team and avoid duplication of effort.

D. The preventive work of the psychologist includes activity in curriculum development through his attendance at meetings of curriculum planning committees. He is able to contribute concepts of developmental readiness with an emphasis upon the emotional effect of specific activities and courses. Because of his awareness of the emotional impact of various kinds of learning experience on individual pupils, he is equipped to make suggestions in this area. For example, one student may require considerable direction while another might profit from a less structured situation. The psychologist perhaps might aid in the development of a course or sequence emphasizing emotional rather than intellectual development. Throughout the country, at all levels of education, attempts are being made to help the student make the best emotional adjustment possible through the teaching of special courses with titles such as "Understanding Yourself," "Mental Hygiene," etc.

E. Another of the psychologist's responsibilities is to encourage and improve where necessary the relationships between the school and the parents through speeches, courses, and individual meetings. He should not limit himself to work with parents of problem children but should attempt to reach the average parent and perhaps in this way prevent a problem before its inception. Fathers should be involved through group meetings which might help them to understand their role in their child's development.

F. The psychologist should assist the school administrator when interpersonal problems arise among teachers, administrative staff, students, or parents. He should assist in developing high morale.

II. Testing and Counseling

A. In carrying on his function of testing and counseling, the psychologist works with children whose needs seem to require special attention. This extends from the children who because of unusual ability or capacity require individual guidance to ascertain their exact intellectual level (with its vocational implications) to the evaluation and placement of retarded students. Curriculum changes might be suggested in the case of the exceptional child so as to prevent personality problems. It is the role of the school psychologist not only to work with and help those children who appear to be below standard but also to point out the abilities of the exceptional child so that he might be better understood and helped to realize his fullest potential.

B. As a result of general psychometric testing in the early grades, those children who appear to be of significantly low intelligence could be retested with individual intelligence tests to verify the intellectual level and rule out, wherever it is possible, personality and other motivational factors which might produce a low score. Those children who are mentally defective should be given a special kind of educational experience appropriate to their intellectual level. The school psychologist must have liaison relationships with the various resources of the community so as to be able to refer such cases for special help.

C. Children who are referred by the classroom teacher and other school officials should be fully evaluated by the school psychologist working in conjunction with the various members of the school staff and other school officials. If the results of their consultation seem to indicate the need for psychotherapy, remedial reading, etc., referral should be made to the proper sources. The parents should be brought into the situation very early so that their fullest cooperation may be gained. The school psychologist should make all school personnel aware of the problem and of the most constructive techniques for handling it.

D. With those children for whom referral is impossible for financial reasons or for lack of local facilities, the school psychologist should begin short-term individual and group counseling. This has the function not only of giving service but

also of breaking down some of the emotional reactions which often arise from the prospect of seeking help outside the school. It is to be hoped that over a period of years teachers working in the remedial areas might profit greatly from participation in this counseling activity. Remedial specialists might act as observers in work with children and, after a period of time, attempt to apply some of these procedures in their own field. Consultative relationships with qualified personnel should be developed by the school psychologist so as to insure the development of the most productive therapeutic plan and application.

E. Time should be made available so that parents might visit the school psychologist and talk over the problems they are having with their children. These problems might relate directly or even indirectly to school matters. When it appears necessary, the parent should be referred to the proper source for more intensive help.

III. Psychometric Group Testing

The school psychologist should develop a program of psychometric testing that grows out of the needs of the school community. A routinized program should be developed under the direction of the school psychologist which would meet the needs of the various departments of the school and the district. Wherever possible and advisable, the psychologist should utilize the services of the clerical staff to assist in the psychometric testing program, so that his time may be effectively used in other areas. In those psychometric tests in which the psychologist must be actively engaged, it would seem best to place the burden of this testing at the beginning and end of the school year when specific individual problems would not be so pressing. The testing procedure should involve a continuing series of achievement tests and appropriately spaced tests of mental maturity. Other specific testing—for vocational advisement, college entrance examinations, etc.—should be brought into the procedure wherever needed.

SPECIFIC PROGRAM

The specific program outlined below is now in operation and is based upon the philosophy of school psychology

described earlier in the paper and upon the reality of beginning such a program with a single psychologist. Any one of the tasks of the school psychologist would be enough to occupy all the time of the worker. A balance must therefore be maintained which would probably not be sufficient in any one area but which would represent a firm program on which to build for the future. It cannot, at this stage of development, be an unchanging schedule of work, for this would not only be impractical but also sterile. Rather, this must be thought of as a descriptive technique of bringing the various contributions of a school psychologist into focus so that the school and the community can evaluate this contribution.

The basic problem that any new psychology program must avoid is to overwhelm the psychologist with a testing program so large that the full value of the psychologist would never be realized. Certainly one of the most important areas of information in a school system is knowledge of the individual differences of the students. Testing will supply this information clearly and numerically. Also, there still exists the old tradition where the school psychologist is thought of as a psychometrician only. Therefore, there inevitably will be great pressure on the psychologist to do more and more testing. This activity must be one aspect of the program but the balance of all the duties of a school psychologist must be maintained or such a regime will be doomed to complete failure, since psychometrics alone can never accomplish the most important and satisfying goals of school psychology.

The school psychologist spends approximately 50 to 53 hours a week in his professional life. This includes his work at the school as well as his continuing growth in the psychological area, his attendance at professional meetings, his community contributions other than his work at the school, and the time to read psychological and educational journals. Of this 53-hour total, the psychologist spends approximately 40 hours a week in his work at the school. The following is a schedule of how he best utilizes his time:

On Monday, Wednesday, and Friday, the schedule is virtually the same in three different schools. Thus, the psychologist spends one full day in a school every two weeks if the

district has six schools. He might make more frequent visits depending upon the needs of the school and the rest of the schedule, but at least one day every two weeks would be given to each school. On these three days, the psychologist goes directly to the school and meets with the school nurse or principal until about 9:30 to discuss specific problems or make plans for the day. From 9:30 to 12:00 the psychologist does individual testing with a child referred by the school. Appointments for the next visit would then be made. The next hour the psychologist does individual or group counseling. From 2:00 until 3:00 the psychologist leads parent group discussions in child psychology organized by the P.T.A. From 3:00 until 4:00 the psychologist does in-service training for teachers through a study of child development as applied to specific classroom problems. From 4:00 to 5:30 appointments would be made with individual parents and teachers to discuss specific children.

Tuesday and Thursday mornings is spent by the psychologist at his office scoring tests and dictating reports and correspondence. From 1:00 until 3:00 he is busy with psychometric testing or other special assignments in any of the schools where it would seem most necessary at that time. From 3:00 to 5:30 he participates in other community activities to allow him to develop in new areas and to become acquainted with people in the community and thus aid him in attaining a broad point of view. This period might be dedicated to further training or teaching in a graduate school of education. The school psychologist regularly plans to spend one evening a week at a P.T.A. meeting of his district. This attendance is as much a part of his job as is the psychological testing he does during the day. His vacations correspond with those of the school. He is, as with other members of the school staff, expected in the summers to continue his training and experience and, if possible, to contribute to psychological journals.

It is to be emphasized that this description represents a sample plan which can be completely altered if needed. It is intended only to illustrate the balance of activities of the school psychologist.

CRITERIA FOR DETERMINING PRIORITIES FOR SERVICES IN MENTAL HYGIENE PROGRAMS

MENTAL HYGIENE DIRECTORS OF GEORGIA'S
LOCAL HEALTH DEPARTMENTS

WHEN the National Mental Health Act, providing grants-in-aid funds, was passed by Congress, in Georgia the Department of Public Health was designated as the State Mental Health Authority. The Division of Mental Hygiene of the health department was given administrative responsibility for developing mental hygiene programs.

As local mental hygiene programs have developed, it has become evident that there was a lack of understanding of their function among public health personnel generally and also among the mental hygiene personnel. It also became apparent that there was a lack of guides for planning and developing programs. Furthermore, the Division of Mental Hygiene lacked funds and personnel to fill all the needs or requests. It seemed wise, therefore, to establish a set of criteria for developing mental hygiene programs which would:

1. Provide guides for program planning and development.
2. Make clearer the function of mental hygiene programs.
3. Make more efficient use of the available funds.

The director of the Division of Mental Hygiene arranged for a series of meetings of the local mental hygiene directors who, on the basis of their accumulated experience at the local level, should be in a position to establish these necessary criteria.

The state director had previously served on a national committee of the Federal Security Agency to develop priorities in health services for children of school age. Following this, he worked with the state and regional health department nutrition staff to develop criteria to determine priorities in nutrition services. Although he shared with the mental hygiene directors of the local centers his experiences from both these pieces of work, the group found it very difficult to think in terms of general criteria applicable to many situations

rather than to a specific problem. It was only after several meetings and a great deal of threshing out of the actual purposes of the criteria that the group began to think in more basic terms.

As the group worked together, it became evident that certain criteria which they suggested for the mental hygiene program were also applicable to all public health services. In view of the fact that these criteria were widely accepted and generally utilized throughout the public health programs, it was decided that this group of criteria would not be included for mental hygiene. Three of the most self-evident of these were:

1. There must be need for the service.
2. There must be skills to carry out the service.
3. The services should affect a maximum number of people.

Nevertheless, there were certain general criteria of this type which, although applicable to all public health services, were sufficiently important at the stage of the development of the mental hygiene program in Georgia for them to be included and used in measuring and contemplating new services.

As the criteria began to take form, they fell into three large groups. Those applicable to:

1. The content of the services.
2. The relationships of the services.
3. The setting in which the services would operate.

Content, relationship, and setting are so closely interwoven that it is possible to place some of the criteria within more than one category. This, however, seemed to be a natural and useful division, and those criteria which were finally accepted will be presented within the framework of this scheme.

CONTENT OF THE SERVICE

When considering a proposed program of service, the content of the service could be evaluated in terms of these yardsticks:

1. *Potential for enhancement of personality, growth, and development.* What potential does this service have for the enhancement of personality, growth, or development? How can it be developed or altered so that it does contain

this potential? This criterion is based upon the assumption that activities should be aimed at strengthening the health aspects of the individual and the community. For example, programs aimed at developing and strengthening leadership qualities in children and adults, or programs which encourage the individual to develop techniques of problem-solving in community groups would be considered as having met this criterion.

2. *Potential for prevention of mental illness.* What potential does this service have for preventing mental illness? This criterion seems to overlap the one just stated, and at some future time they may coincide. However, at the present time, the emphasis seems somewhat different. In the first criterion, we are accepting the fact that we are not attempting to overcome negative factors, but are utilizing or strengthening positive ones. The prevention of mental illness involves overcoming negative factors. An example of a service concerned with negative factors and aimed at the prevention of mental illness would be a maternal deprivation program. The evidence presented in the *Bulletin* of the World Health Organization in 1951 (No. 3, pp. 355-534) by John Bowlby indicates that maternal deprivation is one of the possible roots of mental illness. A program aimed at preventing such deprivation would meet this particular criterion of containing the potential for prevention of mental illness.
3. *Potential for community self-appraisal.* Is there the potential for the community to appraise itself in this program of services? This criterion is differentiated from the regular evaluation that is considered to be necessary for the proper administration of any program. Self-appraisal should not be considered an end in itself. It should lead to new actions for improving the community. The service contemplated should be of the type which would cause the community to take an initial and periodic look at itself so that it may recognize the nature and extent of its mental health problems and be motivated to accept responsibility for bringing about change within these areas.

RELATIONSHIPS OF THE SERVICES

Under this heading we are concerned with the way in which the service being offered by the mental hygiene unit will relate to other individuals, agencies, and services within the community. This group of criteria may overlap somewhat with the group listed under the heading "Setting of the Service," but they deal specifically with relationships.

4. *Potential for reaction with and effect upon persons in authority.* Persons in positions of authority are defined as those in the community whose influence is of such a nature that their opinions would be a factor in implementing the service. As this implies an interaction between the mental hygiene unit and those persons in the community, consideration should be given as to whether the mental hygiene service will:
 - a. Help crystallize the course these people want to take.
 - b. Fit in with their existing goals, activities, and interests.
 - c. Be incorporated into the activities of these persons in a manner which would enhance and expand their goals and interests.

This does not mean a passive acceptance of the attitudes of persons in positions of authority. It does recognize that goals, activities, and interests of mental hygiene personnel and persons in authority may not be the same, so that consideration will have to be given to differences as well as likenesses and to the way in which these would affect each other.

5. *Potential for facilitating communication and preventing isolation among and between communities, administrative units, and individuals.* This criterion states that the service should have the potential for using established channels of communication, opening new ones, and endeavoring to reopen closed ones.

This does not mean that the program will function as a community organization service, but rather, just as it uses its knowledge of interpersonal communication in dealing with individuals, it should also contribute this knowledge to broader aspects of communication and understanding.

6. *Potential for helping raise the general level of the mental health services in the community.* Other agencies and individuals in any community will be performing mental health services. A service similar to one already in existence should not be considered for inclusion in a program. One that might augment those already in existence, however, might be considered. For example, if there is a community psychiatric clinic serving the juvenile court for cases requiring therapy, the same service would not be offered. However, the services of a consultant might be offered to both the court and the clinic to help the court select the cases for which the psychiatric service is most urgently needed. In this way, therapeutic talent could be used more efficiently and the court personnel would learn how best to utilize the service. Another example of a service which would raise the general level of mental health services in a community would be to offer a home-visiting and family casework service for a community clinic.
7. *Potential for mutual strengthening between programs.* This criterion differs from the one above in that it refers to programs other than those which are primarily mental hygiene in focus. It applies to both inter- and intra-administrative relationships. It implies (1) that the services will be set up and administered so that other administrative units will perceive it as supplementing or adding to their services and (2) that the existing community programs will enhance the value of the proposed mental hygiene service.

In a given community, although other administrative units may have their function defined by law so that mental hygiene is not included, inherent in the operation of such units may be activities which are mental hygiene in nature. Such units as juvenile courts, orphanages, county homes would be examples of this. The same is true of welfare departments, rehabilitation programs, crippled children programs, and so forth. In each of these cases, the mental hygiene unit should consider how its service will relate to and help such administrative units, as well as receive added strength from them.

SETTING OF THE SERVICE

The last three criteria pertain to various aspects of the community situation within which the service must operate.

8. *Readiness or contribution to readiness for the service on the part of the community or administrative unit involved.* Is the community or administrative unit ready for this service? Will the service contribute to such readiness? Readiness can be determined by:

1. Attitude of professional personnel in the community toward the service.
2. An expression of conviction by groups and individuals that a mental hygiene service is what the community wants.
3. A community study of its needs and resources.

In some instances, overt indications of readiness may not be apparent, but there will be a seeking for an undefined service, which when analyzed will be found to be an unrecognized readiness for a service in the mental hygiene field. In such a case, the initiation of the mental hygiene service might help to focus or crystallize the community's readiness.

9. *Active public interest and/or contribution to such interest.* Certain activities have special appeal to the public at different times. For example, juvenile delinquency is a subject of nationwide interest at the time these criteria are being developed, so that any service which would relate to the prevention or alleviation of juvenile delinquency or which would contribute to the public interest in alleviation or prevention of juvenile delinquency would be given a higher priority than one related to some need of the community which does not, at the present time, have this kind of interest. This would seem to be a criterion that would be of particular importance in determining which of several services to initiate.
10. *Socio-economic capacity of the administrative unit or community to support the service.* Factors to be considered here would be the attitude of the community toward social programs, the financial capacity of the community, and a general evaluation of the trends of the social and economic development of the community.

A RATING SCHEME

In addition to developing the criteria, the program directors decided that it might be useful to rate these criteria in the order of their importance and to develop a scoring scheme which could be applied to any service which is under consideration. Although such a scoring technique is unreliable, it may prove to be useful as one objective means by which directors of mental health programs could determine the kinds of services which should be given major importance. A rough scale of three steps was applied to the criteria. Those that seemed of primary importance were given a rating of 3. Those next in importance were given a rating of 2, and a criterion of least importance was given a rating of 1.

It is possible to examine several services being considered in light of the number of criteria applicable. Having accomplished this, the system of weights could then be applied to determine roughly the relative significance of the services.

It was concluded, however, that at this time the weight scheme should not be considered too seriously. A total evaluation of the specific community might indicate that criteria given greatest weight by the group are of less importance than most highly weighted criteria, or might even have no importance at all. The table shows the weights which were determined by group consensus.

<i>Criterion</i>	<i>Weight</i>
Readiness for the service on the part of the community or administrative unit involved or contribution to such readiness.....	3
Potential for reaction with, or effect upon, persons in positions of authority	3
Facilitation of communication and prevention of isolation among and between communities, administrative units and individuals.....	3
Enhancement of personality growth and development.....	3
Active public interest and/or contribution to such interest.....	2
Potential for helping to raise the general level of the mental health services in the community.....	2
Potential for the prevention of mental illness.....	2
Potential for community self-appraisal.....	2
Socio-economic capacity of the administrative unit or community to support the service.....	1
Potential for mutual strengthening of programs.....	1

Over a period of four or five years, the criteria will probably undergo many changes. If the weighing system proves useful, efforts will be made toward refinement and toward establishing some measurement of reliability and validity. Our present attitude toward our own criteria is one of cautious acceptance. They have been applied in several instances and found useful. If they can serve the purpose for which they were originally designed, they will be well worth the very considerable time and labor involved in their development.

SUMMARY

The directors of the mental hygiene services of local health departments of Georgia met together at intervals over a period of more than a year to develop a set of criteria to be used:

1. As guides for program planning and development.
2. To make clearer the functions of mental hygiene programs.
3. To make more efficient use of available funds.

In addition to establishing the criteria a tentative weighing system was applied. An attempt is now being made to establish the validity of the criteria through application in local mental hygiene programs.

THE DISTRIBUTION OF MENTAL DISEASE *

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IN spite of its designation and unique stature in the field of the acute communicable diseases, epidemiology has contributed significantly to the understanding of a limited number of non-communicable disorders as well.^{1, 2} Here, as in its more orthodox setting, the discipline has verified and expanded concepts based upon analysis of the individual case.

As a result, current definitions of epidemiology vary remarkably in scope. All, however, stipulate as its general approach the study of the distribution of a disease in a population,³ whereby a search is made for associated variables of possible etiological significance.

The frequency with which a disease occurs may vary within a geographic area over a period of time or may differ among areas at a point in time. Time and place, therefore, become tangible variables for epidemiological study. Both serve as crude indices of other, more elusive factors suspected of being more intimately associated with the disease under investigation. Obviously these significant, reflected variables differ with the disease studied, and are often suggested by prevalent hypotheses concerning etiology, which have emerged from clinical and laboratory study.

In practice, the epidemiological method consists of two consecutive but distinct phases. The first of these entails the identification and collection of meaningful information about those who are ill, for comparison with similar information about those who are well. The second involves the explanation of findings on the basis of either existing knowledge or new

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hypotheses. The second phase, while the more exciting, should not be embarked upon until the accuracy of the first has been established.

In this paper we will review briefly a number of studies, including our own, which have focused upon the mass aspects of mental disorder and which have been reported in the English-language literature. Limited to general descriptive features, the review will summarize major findings which, whether they reject or confirm popular psychiatric tenets, demand thoughtful consideration.

No attempt will be made to discuss attendant statistical problems in all their subtleties. Nevertheless, considerable emphasis will be placed upon technical difficulties encountered through the application, in the field of mental health,⁴ of a method developed and perfected within another compartment of medicine.

Long-Term Trends in Mental Hospital Admissions

Marked increases in the overall rate of admission to mental hospitals, reflected in swelling hospital populations, have occurred during the past century. The same period has witnessed widespread cultural, social, and economic change.

The concurrence of these events suggests their association, but the nature of the association is far from clear. Accepted psychiatric theory would permit the conclusion that a more complex social structure has aggravated the prevalence of mental illness. But first should come assurance that modern society has not merely produced conditions and public attitudes more conducive to the ready hospitalization of those who are ill.

The upward trend in mental hospital admissions has been discussed in numerous articles. Conclusions as to its significance range from those representing carefully considered, but subjective, personal opinion to those based upon the scrupulous analysis of objective data. Among them, a measure of conflict is evident.

For example, it is reported⁵ that when appropriate adjustments were made for changes in types of patients admitted and for other conditions affecting hospitalization, age specific first admission rates below the age of 50 were found not to

have increased in Massachusetts during the past one hundred years. Malzberg,⁶ on the other hand, insists that the first admission trend in New York State can be completely accounted for on no other basis than that of an increasing incidence of mental illness.

In the Province of Ontario,⁷ the population under 65 years of age has suffered no persistent increase in its first admission rate since at least 1927, the year that hospital statistics first were published in a form permitting the age standardization of rates. And since schizophrenia and manic depressive psychosis predominate at these ages, evidence of an increase in the incidence of these psychoses is lacking.

Observations concerning admission trends among the aged are less contradictory and perhaps more easily interpreted. A growing proportion of available mental hospital beds is being occupied by patients 65 years of age and older. Although this is partly the result of an aging general population, most investigators report an upward surge in the age specific rate of first admission as well. In Ontario, this trend has been most evident since 1936.

A growing tendency to hospitalize cases of psychic deterioration in the senium has been suggested as a contributing factor. In addition, our regional analysis of rates in western Ontario showed that rates were highest in counties proximate to a mental hospital, and that when, during the period of study, a new hospital was opened, rates in adjacent counties increased. This suggests that the current and extensive expansion of hospital facilities has influenced the first admission trend among the aged. At the speculative level at least, both of these explanations seem more plausible than that postulating marked increases in the incidence of senile psychosis and cerebral arteriosclerosis.

Apart from their somewhat controversial long-term trend, first admission rates at the younger ages have been reported to exhibit short-term cyclic variations.⁸ In Ontario, they mounted yearly between 1927 and 1935, fell until 1944, and then began another climb.⁷ The fact that this cycle was the inverse of the employment level in the province was particularly significant since the variation in rates was essentially a product of the employed population: males aged 25 to 54.

A possible direct effect of economic stress upon the incidence of mental illness among wage-earning males cannot, of course, be discounted. But perhaps the relationship reflects, in part, an increased need for institutional maintenance of the psychologically handicapped when jobs are at a premium.

The Contemporary Distribution of Mental Illness

Along with attempts to gauge its temporal variation, the literature cites numerous assessments of differences in the frequency of mental illness, at a point in time, among population segments defined by such characteristics as cultural level,^{9, 10} geographic and social area of residence,^{8, 11, 12, 13} economic status, marital status, and place of birth.¹⁴

It is reported that mental illness is not found among remote groups having minimal contact with western culture and that its incidence seems to increase as contact becomes more intimate.^{9, 10} This generality is based upon isolated observations of primitive societies and upon admission data from the few mental hospitals serving such groups. Carruthers¹⁰ states that the rate of admission among Kenya Africans to their mental hospital is only a fraction of the rate for England and North America. Hare⁹ quotes claims of the absence of schizophrenia and, except for brief maniacal attacks, mental illness in general within other specified primitive societies.

But of what significance are such comparisons? Deviant behavior becomes such by cultural declaration. Lack of agreement among definitions of a case can therefore be suspected, particularly when it is remembered that our own concept of mental illness is of rather recent vintage. In addition, differences among hospital admission rates undoubtedly reflect, to an unknown extent, differences in the availability of hospital facilities.

Moreover, the relatively young age composition of most primitive groups becomes an asset; in our society the admission rate increases rapidly with age. And finally, even if the prevalence of mental illness were equal to that commonly estimated for North America, failure, at a point in time, to find a case within a small native tribe would be within the limits of statistical probability. These considerations, we feel,

prohibit a conclusion concerning the effect of western culture upon the incidence of mental illness.

Apart from cultural differences, suspected variation in the incidence and prevalence of mental illness between and within countries has been a topic of study and speculation for many years. About half a century ago, attention was drawn to differences among the states of the United States in the ratio of mental hospital patients to the general population. White,¹¹ in a paper to the National Geographic Society, noted that the highest patient to population ratios were those for areas of greatest population concentration. Considering the differences the reflection of a variation in prevalence, he postulated that mental illness is caused by the stressful struggle for survival and that the struggle grows grimmer with increasing population density.

Perhaps. But then as now states and provinces¹⁵ differed radically in their financial ability to provide hospital facilities. It could have been this inequality rather than actual differences in the prevalence of mental illness that had been gauged.

More recent studies have avoided this complication by being limited to an area served by uniform facilities: a city, state, or province. Significantly, differences among rates of admission to hospital persist. For example, a pioneering analysis¹² of first admission rates in Chicago from 1922 to 1934 revealed that rates for schizophrenia were highest in the central, "disorganized" wards of the city and declined progressively radiating outward to the suburban residential districts.

We have been studying the geographic distribution of admission rates in western Ontario, a circumscribed area having, nevertheless, a population of one million and diversified rural-urban characteristics. The proximity to the university of the two hospitals serving the area has made possible a somewhat detailed analysis of cases.

Our findings have confirmed the effect of population concentration upon the rate of first admission.⁸ During the period 1950 to 1952, the combined crude rate for the five cities with populations of 30,000 or over was 58 percent higher than that for rural areas and villages with populations of under 1,000. Taken as a group, intermediate urban areas had an intermediate rate. As an added observation, the urban excess, while

evident at all ages, was particularly marked at ages 25 to 34 among males and at ages 65 and over among both males and females.

In theory, investigators could measure the effect of myriad social and economic variables upon the rate of first admission. In practice, the indices studied must be restricted to those reported for the general population.

Country of birth is one of these. It has been shown repeatedly that rates for the foreign-born are higher than those for the native-born.^{14, 16} In addition, Odegard established that the rate for Norwegians living in Minnesota was not only higher than that for the natives of Minnesota, but was higher too than the rate for the population of Norway. By diagnosis, the latter excess was one of 700 percent for senile psychosis and cerebral arteriosclerosis and 200 percent for schizophrenia.

The effect of marital status has also been assessed.^{8, 14} Rates for the married group are lowest, followed in order by those for the widowed, single, and divorced and separated. Our data for western Ontario⁶ provided age specific rates for the single, divorced, and separated combined which exceeded those for the married by from 250 percent at ages 15 to 24 to 400 percent at ages 45 to 54. Age specific rates for the widowed were in excess by about 300 percent. Of further interest was the tentative finding that within the married group age specific rates were lowest for those whose marriage had been intact for at least 10 years.

Educational attainment is another associated variable. We, along with other investigators, found that age specific rates were lower for those who had graduated from elementary school than for those who had not. Even at ages 45 to 64 the rate for those with more limited education was in excess by 250 percent.

Unquestionably the foregoing configurations of mental hospital first admission rates are indicative. But of what? They may, it is true, result from an association between the variables studied and the frequency with which mental illness occurs in the population. If this is so, the defined objective of an epidemiological study is within grasp. Information is

at hand which can be used to explore further the social genesis of the disorder.

Of course, the mere association of events does not presuppose their causal relationship. Rather than be under the direct influence of a given variable, the incidence level may be determined instead by the general degree of stability of the population characterized by that variable. This factor of selection may be reflected, for instance, in the low first admission rate for the population married 10 years or more.

But even more disconcerting, the rates may not be a valid measure of incidence at all. They may reflect variation among population segments in the proportion of the mentally ill who avoid hospitalization. The likelihood of admission is undoubtedly influenced by factors such as community tolerance of deviant behavior, resources for home care and protection, and the availability of hospital facilities. Since the quality of these characteristics differs among geographic areas and socio-economic groups, their probable contribution to differences in first admission rates should not be overlooked.

While we were unable to uncover direct proof of the attendance of this complication, some of our statistics were highly suggestive. For example, at the young and intermediate ages the urban excess in the first admission rate was limited almost entirely to males. It is true that males more than females may wilt psychologically under the rigors of urban life. To us, however, it seems more likely that the employed urban male, because of his many and intimate community contacts, is least able to deviate from the norm unnoticed and unchecked.

Perhaps more pointed were observations made concerning rural-urban differences at ages 65 and over. An overall urban excess in the rate of first admission pertained, but when analyzed by 5-year age groups the excess was found to shrink with age and, because of an increasing rural rate, to be replaced, ultimately, by a rural surplus. That this was the result of a greater rural tendency to reserve hospitalization for acute, terminal cases was an inviting explanation given added credence by the discovery of a rural excess in the proportion of patients dying less than one month after admission.

We have provided but two examples of how this kind of interpretation could be attached, with varying degrees of

credibility, to virtually all the reported geographic and socioeconomic variations in rates.

Only passing reference has been made to attempted calculations of the incidence or prevalence of specific diagnostic entities. We consider the slight justified. It was noted by Farrar¹³ some 50 years ago and by Dayton¹⁴ more recently that diagnostic criteria vary so radically, not only from generation to generation but among the psychiatrists of any one generation as well, that comparisons of diagnostic-specific rates should be viewed with misgivings.

While it is to be hoped that a continuing evolution of psychiatric knowledge will eventually alter this state of affairs, an analogue drawn from another field suggests that current studies which judiciously skirt diagnostic analysis need not be unproductive. Communicable disease is now investigated in terms of clearly defined disease entities, but only as a rather recent development. The whole sanitary movement, beginning in the British Isles during the early part of the nineteenth century, stemmed largely from epidemiological observation. And the association of high rates of illness and death with overcrowding and filth was first spotted at a time when diagnostic specification was not considered.

Discussion

Cursory though this review has been, it has surely become evident that attempts to apply epidemiological methods to the study of mental illness are currently fraught with difficulties not foreseen by early champions of the approach. Probably the most fundamental, and without doubt among the more challenging, is that of defining a case of mental illness in objective and universally applicable terms. The potpourri of suggested definitions aired at a recent conference¹⁷ proved that a problem inherent in all types of morbidity studies is unusually vexing here. Diagnostic criteria based upon behavioral norms which in turn can be colored by cultural and social settings are a hazard to studies of this kind.

Should this hurdle be cleared, another is faced. Mental illness, by virtually any working definition, is far from rampant. To count cases in a population sample large enough to

assure the validity of derived statistics would therefore tax the present resources of most research centers.

Until recently, rates of prevalence and incidence have commonly been restricted to those of hospitalized mental illness. In part, this has been because psychiatrists and others directly associated with mental hospitals and their administration have figured prominently in their derivation. But in addition, it has been argued that, however narrow, a case defined as an admission to hospital is shorn of the difficulties just described.

Certainly hospital files contain a wealth of data requiring only a modest outlay of money and manpower to analyze. It would be wrong to turn from this source before garnering its potential yield. In fact, rates of admission to hospital will always have administrative value because regardless of the extent to which they reflect the real need for treatment facilities, they at least spell out the demand and the effect of certain variables upon that demand.

As an index of the distribution of mental illness among geographic areas and socio-economic groups, however, admission rates probably represent a somewhat dubious compromise. Not only does an unknown proportion of the certifiable mentally ill population avoid hospitalization, but there is indirect evidence that this proportion varies under the influence of attitudes, resources for home care, and the availability of hospitals, complicating the interpretation of differences among rates.

Financial support is now being given to attempts to measure, more directly, levels of incidence and prevalence in a sample population. From these studies should come the refinements in methodology needed before the epidemiological approach can fully serve its purpose: that of revealing the environmental concomitants of mental health and disease.

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THE MENTAL HOSPITAL PATIENT IN THE COMMUNITY

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FOR many years the public concern has been with the legality of commitment procedures and the protection of an individual's civil liberties. We still have isolated instances where commitment to mental hospitals is accomplished by trial by jury. The attitude evidently held, and there realistically may still be a residual, was that commitment to a mental hospital was literally slamming a gate behind an individual for the remainder of his days. That commitment to a mental hospital was "a finding" by a group of one's peers depriving a person of his liberty, not a medical determination deciding on hospitalization. The laws still reflect our cultural heritage that mental hospitals are "asylums for the furiously mad." It is only within the last several years that public attention has been turned to the all-important matter of the release of patients from mental hospitals. The stimulus for this interest has again been public concern; anxiety, if you will, lest the public interest is not being adequately protected. Scare headlines, judicial *obiter dicta*, the issue of community protection—all bring into play strong emotions and attitudes which serve to obscure the facts. Unhappily, many of the professionals seek to meet critical charges which are hastily made with equally hasty defenses which would have difficulty surviving careful scientific scrutiny. Out of these defensive positions come catch-phrases or statistical guideposts which are in a sense prefabricated answers to highly emotional attacks. Therefore, when someone accuses hospitals of "loosing lunatics" in the community, we can readily silence them by saying

* Mr. Rockmore, currently principal mental hygienist for the Connecticut Department of Mental Health, and Mr. Feldman, a practicing attorney in New York City, were associated with Dr. Daniel Blain, medical director of the American Psychiatric Association as psychiatric social work and legal consultants in a study of release procedures for mental patients in New York State, undertaken at the request of the Mental Hygiene Council, New York State Department of Mental Hygiene. A report on this study was made available to the public on December 7, 1954.

that ex-mental hospital patients are anywhere from four to 14 times less prone to commit crimes than the general population, depending on which study we are able to quote at any point. The fact is that any statistical study of post state hospital adjustment must be necessarily limited both in conception, by reason of the number of variables, and in implementation, by reason of the complications inherent in the data. The further fact is that a search of the literature will reveal no large scale comprehensive *clinical* study of the mental hospital patients' adjustment after a period of hospitalization.

A rough estimate of the magnitude of the problem, very much on the conservative side, would be that some 200,000 mental patients are yearly discharged from hospital facilities. This admittedly bad guess in no way includes the thousands of hospital patients who may be in the community on convalescent care, extended visit, unauthorized leave, escape, hospital "parole," trial or brief visit, or any number of ways in which a patient is carried on the hospital books while not actually being treated intramurally. Indeed, many of these administrative categories are vital to the treatment program and essential to any community-oriented objective. The word *discharge* is an administrative term which has a specific meaning. It means that an individual is separated from the hospital to the extent that the hospital no longer has any responsibility for him (except in the subtle sense that there is the inference that the ex-patient is no longer in need of treatment). Conversely the patient no longer has access to the facilities of the hospital and in a technical sense these may be denied him until he is readmitted, which means that commitment procedures must start all over again.

It has been noted in estimating the quantitative nature of the problem of release from hospitals offering care and treatment for the mentally ill that if one could add up the number of all those discharged this would only consider one aspect of the mental hospital patient in the community. There are no national estimates¹ of the numbers of individuals who are

¹ From existing reports of "Patients in Mental Institutions—1950-51" (U. S. Department of Health, Education and Welfare) one could include roughly 90,000 patients on record who are *bona fide* patients not within hospital grounds. However, many thousands not reported may well be in communities at any given

currently carried on hospital records as *bona fide* patients who at any one time are not corporeally in the hospital or within hospital grounds. As hospitals have become more and more oriented to treatment and have been administered with an eye toward recovery from mental illness, the return to the community has been very much in the forefront of medical decision. It is accepted that the expectancy of the individual to return to the community is to be stressed as a therapeutically in the recovery process. Accordingly, when a patient shows symptomatic improvement there is a tendency to test out the validity of this improvement by weekend visits, trial or brief visits. As additional experiences with the patient indicate the development of his ability to meet community pressures and demands of the social environment, these visits become extended and may move into the period of convalescent care. It was not so long ago that this term was introduced to replace the penal sounding or inspired "parole." This term, of course, is further extension of the entire history of the association of the care and treatment of mental patients with law, the prisons, and custodial attitudes of protection of the public interest. The concept of convalescent care extramurally is much more in keeping with the medical nature of the decision to release the patient to the next phase of treatment while continuing to make available the hospital facilities, recognizing the hazard of relapse and need for rehospitization without further commitment procedure. In evaluating a mental hospital program, one would be inclined to view the extent to which convalescent care or extended leave is utilized as an indication of the progressive nature of the program. As a guide, one would expect that at least 12 to 15 percent of the population of the hospital would be in the community on any given day. In terms of the overall problem, this would

time. For example, some hospitals situated in communities utilize the concept of "ground privileges" to include the community and surrounding environs. Numbers of patients are employed in communities and return to the hospital after work. As the "night hospital" concept catches on these may increase. There are other means whereby hospital patients may be in the community without appearing on national report forms interested in the administrative movement of patients. Therefore, national estimates on this subject must be taken as minimal and only in relation to specifically tabulated categories.

nationally put well over an additional 125,000 mental patients in our communities.

There are a variety of other ways for a patient to leave the mental hospital and return to the community. Percentage-wise, these additional methods of release represent an insignificant fraction of the problem insofar as numbers are concerned. Yet insofar as public interest and attitude are shaped, threatened, or touched off, they represent the fuse or trigger to what in some instances has been clamor to close the hospital gates or build the administrative release walls to an unsurmountable height. We are referring to patients who have been received through penal code statutes and whose commitment has been the result of criminal behavior for which the individual cannot legally be adjudged to be criminally responsible, or that group of patients who are admitted to a hospital during the time when they are inmates of a penal institution. In either case, the factor of the patient's mental illness is subordinated to his legal status. Thus, an individual in the process of criminal procedure may be committed via legal criteria because he doesn't comprehend the nature of his act and cannot participate in his defense. The hospital authorities under these circumstances may tend to assume the attitude that they are dealing with a "court case" and frequently will hold the patient only until he fulfills *the legal criteria* for release. Thus, when he has clinically recovered to the extent that he can comprehend the nature of his offense and participate in his defense he may be returned to court. It was the general belief, although we know specific situations to the contrary, that such an individual would not be likely to be convicted when tried. The alternatives so far as the community is concerned, therefore, are that either an individual returns unsupervised to the community without having met *medical criteria* as to his readiness to function or, if tried and convicted, he can be sent to prison. There have been situations where patients who had committed a minor criminal offense against property were returned to court under these circumstances, pleaded guilty, and were sentenced to prison. While it is possible to question whether this serves the best interests of the individual (or the community), there can be no question but that the situation in which an "acquitted"

person is turned loose without medical attention or supervision serves neither his own nor the community's interest. The combination of attorneys and psychiatrists who are at this time laboring long and hard to bring the outmoded M'Naghten's Rules up to date may in time remedy this situation. However, hospital superintendents who feel relieved of medical responsibility by fulfilling legal criteria might do well to rethink some of the basic concepts herein involved. Similarly, in the case of voluntary patients who achieve release upon giving due notice rather than as a result of the best clinical judgment there may be considerable hazard. The attitude that the hospital has an implied contractual agreement with a voluntary patient to release him upon due notice is again an abdication of medical responsibility.² The fact that the patient is released "against medical advice" in no way mitigates the need for continued treatment, which the hospital is in the best position to judge and provide.

There are several other methods whereby individuals may be "released" from mental hospitals. While these are not quantitatively significant, they are of importance to the total comprehension of the subject. One such deserves particular mention. This is release via a writ of *habeas corpus*. Again it reflects the attitude of the community against unwarranted deprivation of an individual's liberty and very necessary vigilance exercised against any infringement upon civil rights. However, with this guarantee present, the principle of medical judgment concerning continued hospitalization or release should be basic to a consideration of the individual's and the community's best interests.

Our study of release procedures was occasioned by a few well-publicized crimes committed by individuals who had been identified as ex-mental patients. The publicity was touched off by statements in the press by responsible public officials that there was a direct relationship between the procedures of releasing mental patients and the incidence of crime. The statements were accusatory rather than inferential. The inference was that release from mental hospitals should be accomplished by legal proceedings rather than medical de-

² Except in those instances where the release of voluntary patients upon due notice is mandatory by statute.

cision. Although the study was unfortunately stimulated by placing the care and treatment of the mentally ill in juxtaposition with criminal activities, it may have had a salutary effect in alerting both the mental hospitals and the public to a continuing responsibility to strengthen our services and practice in the mental health field. It almost placed a survey of the situation in a position to prove or disprove the fact that the practice of releasing patients was good or bad and that the ex-patient was a greater or lesser risk to life and property than the general population. The approach to the study attempted to transcend this limitation and accomplish an overall view of these procedures.

In the course of the study, the specific experience of legal proceedings in which "insanity" was introduced as a defense against responsibility for criminal behavior was scrutinized case by case. This method offered an excellent opportunity to study individual case situations in which the ex-patient could be followed through a number of institutional and community procedures. It became possible through a search of the records of a criminal court handling probably the largest volume of such proceedings over a period of almost five years. It was determined that in only 37 percent of the cases studied the defendant had been a mental patient prior to these "lunacy" proceedings.

Accordingly, a qualitative case study of these individual cases was undertaken. For although these few cases represented a statistically insignificant percentage of the ex-mental patient population it was quite clear that they were a potentially explosive force sufficient to emotionally arouse the public to a pitch where hasty and ill-advised measures might be invoked which would effect the treatment of some 750,000 patients whose eventual recovery might depend on their hope of returning to the community. Moreover, wherever there is a barrage of unfavorable publicity there tends to be a temporary corresponding diminution of release.

For purposes of illustrating the variety of methods whereby individuals return to the community, this small group of cases was very illuminating. In all, they left mental institutions and returned via eleven different routes. In addition to some of these already mentioned—e.g., direct discharge, discharge

from convalescent care, return to court or prison, *habeas corpus*, etc.—some interesting percentages were revealed. For example, 10 percent left their hospitals by escaping. Return to court for trial or transfer to another facility was the way out for 27 percent. Eighteen percent of the group originally were voluntary admissions. Lest this experience with ex-patients who were involved in one local court be considered atypical or provincial it should be stated that one-third of the cases had been “released” from mental institutions of other states or the federal government.⁸ To further identify this group, 77 percent of them had had histories of criminal arrests prior to their first admission to a mental hospital. Despite this fact, criminal activity played a vital role in the first admission of only 57½ percent of the group. At the point where this group came under scrutiny almost half of them had been readmitted to hospitals three or four times.

At least by indirection a strong case has been made that the manner by which an individual enters a hospital may condition or even dictate by statute the means whereby he returns to community life. In a sense, the method of entry also conditions the degree to which the hospital thinks of its responsibility and usually the extent to which after-care services are made available. A voluntary admission is under these circumstances thought of as a “contractual agreement,” a criminal order commitment is a “court case.” Similarly, where admission is achieved by a physician’s or health officer’s emergency commitment, the hospital assumes temporary or limited responsibility, and separation from the hospital is accomplished by “direct discharge.” In many other instances the direct discharge is discretionary with hospitals and the patient returns to his social milieu without the benefit or access to the supportive help which may be indicated. Since the social services available in most hospitals to work with the environmental problems which may have been related to precipitating a patient’s illness are pitifully inadequate, a cynical approach

⁸ The interstate complications of the problem are manifold. A committee with the help of the Council of State Governments from the Northeast State Governors’ Conference on Mental Health has drawn up an interstate compact now beginning to be introduced into state legislatures. Connecticut became the first state to ratify this compact in December, 1955.

would not highlight this aspect of the problem. Yet data is available which conclusively supports the thesis that patients released under convalescent care are less a hazard to the community and to themselves. Even in the group of criminal proceedings mentioned herein only $16\frac{2}{3}$ percent were under convalescent care at the time when they committed the act which brought them into court.

The problem of the release of mental patients is a very intricately involved matter, as this discussion implies. It requires a careful analysis of types of commitment, the entire in-patient program, the discharge procedure, the after-care program; it embraces all manner of administrative problems, personnel, and plant facilities, interdepartmental relations and interstate problems; it cuts across medical and legal traditions and philosophy as well as scientific problems and the strength or weakness of professional judgment. Add to these technical factors the weight of increasing numbers and the volatile nature of public opinion. A sober inventory of these variables would raise question concerning the responsibility of accusatory statements or the service of statistical defenses to the basic data requiring careful evaluation. It is small comfort to the victims when they know that the incident which affects their lives is even statistically insignificant. On the other hand, it is no small task to carry the responsibility for patients without adequate staff or facilities. It has been well publicized that there is a paucity of leads to the development of preventive efforts in the field of mental illness. One of the areas which would bear investigation, case by case, is the relapse of patients who have clinically recovered.

The best information in the field understands that most mental illness occurs when there is a combination of two factors: (1) the basic personality structure of the individual; (2) overwhelming forces in the environment which result in breakdown. In the military service during wartime it was an accepted principle that every serviceman had his breaking point depending upon the environmental stress to which he was exposed. It was on this basis that attempts were made to determine the length of time and the conditions under which units could perform most efficiently. Civil life has stresses and strains of a sometimes more subtle nature but no less tax-

ing over a period of time than the more obvious combat threat to physical and emotional well-being. The mental hospital in a sense offers a haven, a shelter, or even the counterpart of the military neuro-psychiatric reconditioning facility in such instances. As the mental hospital has become more of a treatment and less of a custodial institution the chances of clinical recovery have become brighter. With the advent of various means of intervention available to psychiatry and currently being developed, more and more patients are becoming accessible to preparation for return to the community. There are only isolated psychiatric facilities which lay claim to changing the basic personality structure of their patients. There are a few who while the individual is hospitalized concurrently work to understand and ameliorate the environmental forces to which he has succumbed. Therefore, the individual, who in the hospital appears symptom-free, usually returns to essentially the same environment with much the same personality structure in which his illness was nurtured. The interesting phenomenon is that with this empirical knowledge the mental hospitals with notable exceptions haven't given a higher priority to their after-care and community related programs. One can only guess that other primary pressing problems have absorbed much of their energy. Otherwise, one would assume that there would at least be careful studies of rates of readmission and case-by-case analysis in an attempt to determine factors related to the recurrence of mental illness. Otherwise, there would be a reluctance to release patients unless they were placed in convalescent status with the supportive help that it implies. Otherwise, additional professional time, energy, and funds would be made available to after-care clinical services.

This point is important because, implicit in questions raised about release procedures, it is sometimes inferred that the clinical judgment was faulty when the patient either commits a crime or has to be returned to the hospital because his symptoms have become exacerbated. While inevitably some clinical judgments may be either unsound or based on incomplete knowledge of the patient, clinical judgment is nonetheless the very best device available for predicting the patient's behavior or assessing his current status. However,

as the patient returns to his everyday pursuits and is subject to the pressures of decisions, family relations, and responsibilities, the clinical picture upon which release was predicted is bound to change. It is at this point that additional props and supports are necessary for him to consolidate the gains made during hospitalization, lest he again find himself unable to cope with his emotional problems and need to be returned to the hospital. Indeed, it may be that until much more is learned about the causes of mental illness and the courses of disease entities that the ex-mental patient may do best with continued supportive help in the community. This would negate any use of the concept of direct discharge or the arbitrary period of convalescent care, e.g., one year, used in some states.

And lest our fiscally minded friends belabor the cost of such an operation, it would be well to measure the cost of a patient on convalescent care against the cost of rehospitization. In the face of the quantitative nature of the problem, the estimates for capital outlay required to meet the increased patient population should be proportionately added to the cost of convalescent care per patient per year.

This brief discussion of the release of mental patients is intended to stimulate thinking in an area too long neglected in informed lay and professional circles. It is hoped that panic can be forestalled by careful collection of data when a wanton homicide is committed by a psychotic individual. It is hoped that activity in these informed groups will go beyond statistical sedatives to the case content for basic evaluation. A definitive treatise on release needs to be done; it would have to embrace every facet of the care and treatment of the mentally ill, of which release is only one vital procedure.

THE DURHAM DECISION—A BEACON IN THE DARK

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ON July 13, 1951, Monte Durham, a frequently-in-trouble young man of 23, with a long previous history both of imprisonment and mental hospitalization, got into trouble once again. This time he was arrested for housebreaking. In due time he was tried, convicted, and sentenced to prison, in spite of his plea of not guilty by reason of insanity.

Almost exactly three years later, July 1, 1954, the U. S. Court of Appeals for the District of Columbia, in a most enlightened and scholarly opinion written by Judge David L. Bazelon with Judges Henry W. Edgerton and George T. Washington concurring, reversed his conviction in the lower court and ordered a new trial. Why? "... because the trial court did not correctly apply existing rules governing the burden of proof on the defense of insanity." The Appeals Court went on to hold that "existing tests of legal responsibility are obsolete and should be superseded."

With this momentous decision there opened a truly promising chapter in the history of the relationship between psychiatry and the law.

The courageous decision was met with mixed reactions. There were the usual "viewers-with-alarm," but over and above the din came clear and glowing praise from leaders in both law and psychiatry.

Why all the excitement? "Not guilty by reason of insanity" has been a proper legal defense for centuries. When, to the satisfaction of a judge or jury, the accused was of "unsound mind" at the time of the commission of an unlawful act he was usually found "not guilty." Then what is so important about the Durham decision? How does it differ from earlier views?

The difference lies in the answer to the question: How can the judge or jury know that the defendant was of unsound mind at the time of the commission of his crime?

Now, common sense would say that perhaps one should call in the doctors of the mind—psychiatrists—and simply ask them, “Was the accused mentally ill and was his crime a product of his illness?” But common sense was quite uncommon insofar as this problem presented itself to the judge and jurors. In spite of repeated protests from leaders in psychiatry and the law, the courts of our land, with the exception of those in New Hampshire (since 1870), have consistently been guided by an outmoded and unscientific set of criteria: namely, the M’Naghten Rule.

The reader is undoubtedly familiar with this vexing legal test for insanity. In England, in 1843, the defendant, M’Naghten, was acquitted in a murder trial when he pled insanity as a defense. Following his acquittal and the subsequent intense discussion and debate in the House of Lords, the fifteen judges of England established a rule or test to determine the responsibility of a person who in his defense pled insanity at the time of the crime:

To establish a defense on the ground of insanity it must be clearly proved that at the time of committing the act the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.

This “right and wrong” test became the basic guidepost in the years that followed, not only in England but also in the United States. (One notable exception was New Hampshire, which in 1870 established substantially the same rule as the recent Durham decision.)

Now the M’Naghten rule, seen in the perspective of 113 years, was actually an attempt at being fair. It was, at the time it was established, more considerate of the state of mind of the accused than were earlier (i.e., *before* 1843) views. Yet, as we are seeing, it was not only far from adequate in the criteria that it required be met—it was even more negative since it froze into legal language a particular set of medical ideas, current at that time, and compelled subsequent generations to be bound to them, in spite of the general recognition that medical concepts are not static but ever changing and growing in the light of newer research and experience. Common sense would say: Let the psychiatrist say whether a man

is of unsound mind and let him say so in the light of the latest scientific knowledge. M'Naghten says, "Certainly let the psychiatrist talk, but he must talk in the concepts of the medical knowledge of 1843!"

Of the M'Naghten rule, Mr. Justice Cardozo said many years ago, "Everyone concedes that the present definition of insanity has little relation to the truths of mental life. . . . If insanity is not to be a defense, let us say so frankly and even brutally, but let us not mock ourselves with a definition that palters with reality. Such a method is neither good morals nor good science nor good law."¹

The Royal Commission which concerned itself with this problem in England said in 1953, "... the test of responsibility laid down in England by the M'Naghten Rules is so defective that the law on the subject ought to be changed."²

And Mr. Justice Frankfurter has said, "... I do not see why the rules of law should be arrested at the state of psychological knowledge of the time when they were formulated. . . . I think the M'Naghten Rules are in large measure shams. . . . I dare to believe that we ought not to rest content with the difficulty of finding an improvement in the M'Naghten Rules."³

In 1951, the Chief Judge of the Third Judicial Court of the United States, John Biggs, Jr., said in a dissent, "The rule of M'Naghten's Case was created by decision. Perhaps it is not too much to think that it may be altered by the same means."⁴

And the Committee on Psychiatry and Law of the Group for the Advancement of Psychiatry stated in its May, 1954 report on *Criminal Responsibility and Psychiatric Expert Testimony*, "Although the M'Naghten Rules have a history of over one hundred years in the American judicial system, psychiatric expert testimony in capital cases has brought little satisfaction to either the lawyer or the psychiatrist . . . recent and rapidly developing knowledge of mental life now challenges traditional concepts and brings the central issue of responsibility and

¹ Quoted by Judge Sobeloff in an address to the National Conference of Bar Councils, in Washington, D. C., May 19, 1955.

² Royal Commission on Capital Punishment, H. M. Stationary Office, 1953.

³ In a statement to the Royal Commission.

⁴ United States ex rel. Smith v. Baldi, 192 F. (C.A. 3d, 1951).

mental illness into sharper relief. . . . The committee recommends the abolition of the M'Naghten Rules. . . ."

And, indeed, two months later, in July of 1954 the U. S. Court of Appeals for the District of Columbia did just that for the courts in its jurisdiction!

What is the real difference between the M'Naghten rule and the Durham decision? Both support the principle that if at the time an unlawful act is committed the accused be of unsound mind he ought not be held criminally responsible. The difference in the two rulings is most important. The M'Naghten rule lays down *specific symptoms* as the test for an unsound mind—as such, it is an extremely narrow and rigid test dealing with but a fraction of the functions of the total personality. To meet the criteria of the M'Naghten rule the accused must be so completely demented or mentally deficient that his intellect, his cognitive functions, are practically non-existent. Understandably, the medical thinking of over 113 years ago is far removed from the knowledge which modern psychiatry possesses about the human personality. The M'Naghten rule is based on the grossly erroneous assumption that man is essentially a *rational* animal who can, by use of his reason, *control* his behavior and hence can be held *accountable* for his conduct.

For decades, psychiatrists and others have known that this view of man is highly invalid. Man is an integrated personality and reason is but one factor—and a small one, at that, in determining his conduct. Over the years, the role of emotions in determining human behavior has been increasingly seen to be the major determinant of man's actions. Anyone can give ample testimony to the fact that there are too many occasions when though he "reasons" and "wills" to do one way he finds himself acting-out in quite a contrary fashion! The ability, then, to control impulses which arise from deep within us so that we always lead rational, ordered, and responsible lives is certainly a precious one, quite difficult to achieve. Today, we know that only a relatively healthy ego can manage to mediate, with reasonable success, between our inner impulses and motivations and the external demands of the society in which we live. Today, we know that an impaired ego is so easily defenseless against an avalanche of primitive

wishes and drives which seek expression and fulfillment regardless of what society may say, or even against what one's more recently acquired conscious values may counsel to the contrary.

The Durham decision, in keeping with the ethical desire to see that the man of unsound mind is not unfairly held accountable has brought the legal test for insanity up to date. And what shall the test be? All that Durham says is that there is *no simple or single test for mental illness*. A disturbance in the intellectual or cognitive functions (M'Naghten) is no more an accurate measurement of unsound mind than is high fever the sole criterion upon which to base a diagnosis of pneumonia.

Durham says that the essence of the problem "*is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect.*" But, unlike M'Naghten, the Durham rule refuses to write a legal set of criteria as to what constitutes insanity—this being quite properly a medical question. A man may be insane in the old M'Naghten sense, he may be insane in the "irresistible impulse" sense, or he may be insane in any other way in which the psychiatrist can show that he is.

Judge Simon E. Sobeloff, Solicitor General of the United States, said "Last July, the Court of Appeals for the District of Columbia Circuit handed down a notable opinion . . . relieving the courts in this jurisdiction of the unbending M'Naghten rule with its discredited right-wrong test. The full merit . . . is precisely that they do not attempt to embody one set of medical theories in place of another, for even if it were possible to frame a test embodying more modern knowledge there would still be the danger that in the progress of science the new rule itself might be found inadequate."⁵

With one clean and simple stroke the taut spring which kept the law lagging over a century behind modern medical knowledge was broken and now the courts, at least under the jurisdiction of the United States Court of Appeals for the District of Columbia (as well as in New Hampshire) may more accurately and fairly administer justice in cases where the accused

⁵ In an address to the National Conference of Bar Councils, in Washington, D. C., May 19, 1955.

pleads not guilty by reason of insanity. Henceforth a testifying psychiatrist will not be required to sit idly by and watch an individual whom he knows to be anti-social because of mental illness go to prison instead of to a hospital for treatment merely because the accused knew what he was doing and knew that it was wrong. On the other hand, no psychiatrist, because of his inner belief that a helpless person should not be punished, need lie and say that the accused meets the M'Naghten test when in fact he does not. Now the psychiatrist need but speak as a doctor and not as a moralist or crystal-ball gazer. Now he need but testify whether mental illness was present at the time of the commission of the crime and whether the unlawful act was a product of the mental illness. From that time on it is up to the fact-finder—whether a judge or a jury—to determine whether the accused is sane or insane, (i.e., by accepting or rejecting psychiatric testimony).

And if the accused is acquitted by reason of insanity (and even if it be claimed that he has since recovered) he must be sent to a mental hospital for observation and whatever treatment is indicated, until such time as the hospital authorities say that he is well and that it is reasonable to assume he is not likely to be a danger to himself and to others.

Thus the Durham decision sets into motion a more enlightened and socially useful process: Society is protected by removal of the offending individual—but removed not to prison where after a fixed time (or sooner, on “good behavior”) he is released to repeat (80 percent) a criminal life—but rather removed to a hospital where he can be treated and, hopefully, rehabilitated. Hospitalization and treatment gives society a better chance to avoid further trouble—and gives the individual the only chance he can have to repair, to grow up emotionally, to discover, perhaps for the first time, that a non-criminal, socially responsible way of life may indeed be learned and practiced.

But this presents psychiatry with a serious challenge. Very well, says the law, you now have won your point. The accused acted because of his mental illness. We send him to you for treatment rather than to prison. Can you really help him? Treated by you is he less apt to be a recidivist than is a graduate of our penitentiaries? And while we are asking

questions, we would also ask, have you enough psychiatrists in training for this work? Is there enough active research in the psychopathology of criminal behavior? Are you really ready for the task ahead?

* * * *

With the so-obvious gain in the Durham decision one wonders why it took so long for its underlying point of view to establish itself in the area of criminal responsibility. From M'Naghten to the New Hampshire rule was a span of twenty-seven years. The New Hampshire rule, based on the magnificent teaching of Dr. Isaac Ray (author of the classic, *Medical Jurisprudence of Insanity*, in 1838) refused to specify the criteria of insanity—leaving that task to the doctors, just as Durham does today. Yet, for not-so-strange reasons the New Hampshire rule did not become a model for the other courts of our land.

At the root of this problem lies the disturbing question of "free will." Dynamic psychiatry, with its base in psychic determinism, presents lawyers with facts which alarm many and disturb practically all. For if, indeed, man is hardly the free agent which the law, and for that matter, the man-on-the-street, assumes, what happens to moral blame? How can one blame where one can't be held fully responsible, fully free to choose his course of action, fully able to control his inner sources of motivation?

This age-old problem does, indeed, vex not only the responsible lawyer but also all other thoughtful people who note the great gap between what the law assumes in its concept of criminal responsibility and what the facts about man's "freedom" are in actuality.

The problem of reconciling *feelings* of "freedom" with the *fact* of psychic determinism is far from solved. Capacity for responsibility grows as the ego matures into a healthy, functioning part of the personality. Conversely, an impaired ego diminishes the capacity for responsibility. Yet, whether the ego is impaired or unimpaired is itself the result of antecedent factors over which the individual has so little to say. However, as a practical need, concessions are made by admittedly shelving the problem and acting upon the assumption that man has a "free will."

Commenting on this point, W. G. Katz, professor of law at the University of Chicago, says, "Laying aside the question of the reality of free will, lawyers and psychiatrists can agree that the great majority of people should be treated *as if* they had free will. Indeed, careful judges often speak of legal responsibility as based upon an assumption of free will. Thus, Mr. Justice Cardozo spoke of the law as 'guided by a robust common sense which assumes the freedom of the will as a working hypothesis in the solution of its problems.' It is agreed, therefore, that most people should be treated as if their actions proceeded from free choice. But it is also agreed that such treatment is inappropriate for some individuals. How is this minority to be identified? This is the problem of the Durham case."⁶

So slowly did the wheels of legal progress turn in this matter of criminal responsibility. So fearful were some to admit and operate on the truth that man is far from being an entirely rational, able-to-control, and therefore responsible person. For if we admit to this, what happens to criminal responsibility?

One hundred and eleven years after M'Naghten and eighty-four years after the New Hampshire rule, Judge Bazelon and his colleagues courageously undertook to point to the answer. Nothing unfair, nothing adverse need happen to the concept of criminal responsibility. Not getting seriously involved in a discussion for-or-against the existence of "free will," Judge Bazelon says in effect that when, at least, you do know that there is no freedom of will to control anti-social behavior (as, for example, when the unlawful act stems from mental illness) let us at least here act in keeping with the facts.

"The legal and moral traditions of the western world," Judge Bazelon wrote, "require that those who, of their own free will and with evil intent (sometimes called *mens rea*), commit acts which violate the law, shall be criminally responsible for those acts. Our traditions also require that where such acts stem from and are the product of a mental disease or defect, as those terms are used herein, moral blame shall not attach, and hence there will not be criminal responsibility."

⁶ *University of Chicago Law Review*, Vol. 22, No. 2, Winter 1955, p. 398.

"This really means then that the law finally comes around to admitting that we are not as free as the law has always presumed that we were," said Dr. Karl A. Menninger, "I think the Durham decision is the greatest advance we have had in this matter for the past one hundred years."⁷

"Judge Bazelon's opinion," said Dr. Gregory Zilboorg, "viewed against the background of history, marks a turning point in a struggle which has been familiar to us for at least four hundred years. . . . Seldom is history made with such unassuming quietness and almost self-effacing modesty, without loud headlines and without self-serving pronouncement. But this is great history in the making."⁸

A careful reading of the decision itself, reprinted in the following pages, will show why leaders in both psychiatry and law have praised it so freely and eloquently.

⁷ Personal communication.

⁸ *University of Chicago Law Review*, Vol. 22, No. 2, Winter 1955, pp. 332 and 335.

Special Article

UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 11859

MONTE W. DURHAM, APPELLANT

v.

UNITED STATES OF AMERICA, APPELLEE

Appeal from the United States District Court for the District of Columbia

Decided July 1, 1954

Mr. Abe Fortas, appointed by this Court, with whom *Mr. Abe Krash* was on the brief, for appellant.

Mr. Gerard J. O'Brien, Jr., Assistant United States Attorney, with whom *Messrs. Leo A. Rover*, United States Attorney, and *Lewis A. Carroll* and *Arthur J. McLaughlin*, Assistant United States Attorneys, were on the brief, for appellee. *Mr. William J. Peck*, Assistant United States Attorney at time record was filed, entered an appearance for appellee.

Before EDGERTON, BAZELON and WASHINGTON, Circuit Judges.

BAZELON, *Circuit Judge*: Monte Durham was convicted of housebreaking,¹ by the District Court sitting without a jury. The only defense asserted at the trial was that Durham was of unsound mind at the time of the offense. We are now urged to reverse the conviction (1) because the trial court did not correctly apply existing rules governing the burden of proof on the defense of insanity, and (2) because existing tests of criminal responsibility are obsolete and should be superseded.²

I

Durham has a long history of imprisonment and hospitalization. In 1945, at the age of 17, he was discharged from the Navy after a psychiatric examination had shown that he suffered "from a profound personality disorder which renders him

¹ D. C. Code §§ 22-1801, 22-2201 and 22-2202 (1951).

² Because the questions raised are of general and crucial importance, we called upon the Government and counsel whom we appointed for the indigent appellant to brief and argue this case a second time. Their able presentations have been of great assistance to us. On the question of the adequacy of prevailing tests of criminal responsibility, we received further assistance from the able brief and argument of Abram Chayes, *amicus curiae* by appointment of this Court, in *Stewart v. United States*, No. 11891, *sub judice*.

unfit for Naval service." In 1947 he pleaded guilty to violating the National Motor Theft Act³ and was placed on probation for one to three years. He attempted suicide, was taken to Gallinger Hospital for observation, and was transferred to St. Elizabeths Hospital, from which he was discharged after two months. In January of 1948, as a result of a conviction in the District of Columbia Municipal Court for passing bad checks, the District Court revoked his probation and he commenced service of his Motor Theft sentence. His conduct within the first few days in jail led to a lunacy inquiry in the Municipal Court where a jury found him to be of unsound mind. Upon commitment to St. Elizabeths, he was diagnosed as suffering from "psychosis with psychopathic personality." After 15 months of treatment, he was discharged in July 1949 as "recovered" and was returned to jail to serve the balance of his sentence. In June 1950 he was conditionally released. He violated the conditions by leaving the District. When he learned of a warrant for his arrest as a parole violator, he fled to the "South and Midwest obtaining money by passing a number of bad checks." After he was found and returned to the District, the Parole Board referred him to the District Court for a lunacy inquisition, wherein a jury again found him to be of unsound mind. He was readmitted to St. Elizabeths in February 1951. This time the diagnosis was "without mental disorder, psychopathic personality." He was discharged for the third time in May 1951. The housebreaking which is the subject of the present appeal took place two months later, on July 13, 1951.

According to his mother and the psychiatrist who examined him in September 1951, he suffered from hallucinations immediately after his May 1951 discharge from St. Elizabeths. Following the present indictment, in October 1951, he was adjudged of unsound mind in proceedings under § 4244 of Title 18 U.S.C., upon the affidavits of two psychiatrists that he suffered from "psychosis with psychopathic personality." He was committed to St. Elizabeths for the fourth time and given subshock insulin therapy. This commitment lasted 16 months—until February 1953—when he was released to the custody of the District Jail on the certificate of Dr. Silk, Acting Superintendent of St. Elizabeths, that he was "mentally competent to stand trial and * * * able to consult with counsel to properly assist in his own defense."

He was thereupon brought before the court on the charge involved here. The prosecutor told the court:

"So I take this attitude, in view of the fact that he has been over there [St. Elizabeths] a couple of times and these cases that were charged against him were dropped, I don't think I should take the responsibility of dropping these cases against him; then Saint Elizabeths would let him out on the street, and if that man committed a murder next week then it is my responsibility. So we decided to go to trial on one case, that is the case where we found him right in the house, and let him bring in the defense, if he wants to, of unsound mind at the time the crime was committed, and then Your Honor will find him on that, and in your decision send him back to Saint Elizabeths Hospital, and then if they let him out on the street it is their responsibility."

Shortly thereafter, when the question arose whether Durham could be considered competent to stand trial merely on the basis of Dr. Silk's ex parte statement, the court said to defense counsel:

³ 18 U.S.C. § 408 (1946).

"I am going to ask you this, Mr. Ahern: I have taken the position that if once a person has been found of unsound mind after a lunacy hearing, an ex parte certificate of the superintendent of Saint Elizabeths is not sufficient to set aside that finding and I have held another lunacy hearing. That has been my custom. However, if you want to waive that you may do it, if you admit that he is now of sound mind."

The court accepted counsel's waiver on behalf of Durham, although it had been informed by the prosecutor that a letter from Durham claimed need of further hospitalization, and by defense counsel that " * * * the defendant does say that even today he thinks he does need hospitalization; he told me that this morning."⁴ Upon being so informed, the court said, "Of course, if I hold he is not mentally competent to stand trial I send him back to Saint Elizabeths Hospital and they will send him back again in two or three months."⁵ In this atmosphere Durham's trial commenced.

His conviction followed the trial court's rejection of the defense of insanity in these words:

"I don't think it has been established that the defendant was of unsound mind as of July 13, 1951, in the sense that he didn't know the difference between right and wrong or that even if he did, he was subject to an irresistible impulse by reason of the derangement of mind.

"While, of course, the burden of proof on the issue of mental capacity to commit a crime is upon the Government, just as it is on every other issue, nevertheless, the Court finds that there is not sufficient to contradict the usual presumption of [sic] the usual inference of sanity.

"There is no testimony concerning the mental state of the defendant as of July 13, 1951, and therefore the usual presumption of sanity governs.

"While if there was some testimony as to his mental state as of that date to the effect that he was incompetent on that date, the burden of proof would be on the Government to overcome it. There has been no such testimony, and the usual presumption of sanity prevails.

* * * *

⁴ Durham showed confusion when he testified. These are but two examples:

"Q. Do you remember writing it?

"A. No. Don't you forget? People get all mixed up in machines.

"Q. What kind of a machine?

"A. I don't know, they just get mixed up.

"Q. Are you cured now?

"A. No, sir.

"Q. In your opinion?

"A. No, sir.

"Q. What is the matter with you?

"A. You hear people bother you.

"Q. What? You say you hear people bothering you?

"A. Yes.

"Q. What kind of people? What do they bother you about?

"A. (No response.)"

Although we think the court erred in accepting counsel's admission that Durham was of sound mind, the matter does not require discussion since we reverse on other grounds and the principles governing this issue are fully discussed in our decision today in *Gunther v. United States*.

⁵ The court also accepted a waiver of trial by jury when Durham indicated, in response to the court's question, that he preferred to be tried without a jury and that he waived his right to a trial by jury.

"Mr. Ahern, I think you have done very well by your client and defended him very ably, but I think under the circumstances there is nothing that anybody could have done." [Emphasis supplied.]

We think this reflects error requiring reversal.

In *Tatum v. United States* we said, "When lack of mental capacity is raised as a defense to a charge of crime, the law accepts the general experience of mankind and presumes that all people, including those accused of crime, are sane."⁶ So long as this presumption prevails, the prosecution is not required to prove the defendant's sanity. But "as soon as 'some evidence of mental disorder is introduced, * * * sanity, like any other fact, must be proved as part of the prosecution's case beyond a reasonable doubt.'"⁷ Here it appears that the trial judge recognized this rule but failed to find "some evidence." We hold that the court erred and that the requirement of "some evidence" was satisfied.⁸

In *Tatum* we held that requirement satisfied by considerably less than is present here. *Tatum* claimed lack of memory concerning the critical events and three lay witnesses testified that he appeared to be in "more or less of a trance," or "abnormal," but two psychiatrists testified that he was of "sound mind" both at the time of examination and at the time of the crime. Here, the psychiatric testimony was unequivocal that Durham was of unsound mind at the time of the crime. Dr. Gilbert, the only expert witness heard,⁹ so stated at least four times. This crucial testimony is set out in the margin.¹⁰ Intensive questioning by the

⁶ 88 U.S.App.D.C. 386, 389, 190 F.2d 612, 615 (1951).

⁷ 88 U.S.App.D.C. at 389, 190 F.2d at 615, quoting GLUECK, *MENTAL DISORDER AND THE CRIMINAL LAW* 41-42 (1925).

⁸ In its brief, the prosecution confounds the "some evidence" test with the "evidence sufficient to create a reasonable doubt" test, despite our explanation in *Tatum* that the "'evidence sufficient to create a reasonable doubt' test" applies only after the issue has been raised by "some evidence" and the burden is already upon the Government to prove the defendant's sanity beyond a reasonable doubt. 88 U.S.App.D.C. at 390, 190 F.2d at 616.

⁹ Dr. Amino Perretti, who also examined Durham in connection with those proceedings and furnished an affidavit that Durham was of unsound mind, was unable to testify due to illness.

¹⁰ (1) "Q [Mr. Ahern]. As a result of those examinations did you reach a conclusion as to the sanity or insanity of the defendant?

"A. Yes, I did arrive at an opinion as to his mental condition.

"Q. And what is that opinion?

"A. That he at that time was of unsound mind.

"Q. Can you tell us what disorder he was suffering from, Doctor?

"A. The report of this case at the time, as of October 9, 1951, I used the diagnosis of undifferentiated psychosis, but according to the record the diagnosis was at the time of commitment psychosis with psychopathic personality.

"Q. At that time were you able to make a determination as to how long this condition had existed?

"A. According to the record I felt at the time that he had been in that attitude or mental disorder for a period of some few to several months."

(2) "Q [Mr. Ahern]. Directing your attention specifically to July 13, 1951, will you give us your opinion as to the mental condition of the defendant at that time?

"A. From my previous testimony and previous opinion, to repeat, it was my opinion that he had been of unsound mind from sometime not long after a previous release from Saint Elizabeths Hospital [i.e., May 14, 1951]."

(3) "Q [Mr. Ahern]. In any event, Doctor, is it your opinion that that period of insanity would have embraced the date July 13, 1951?

"A. Yes. My examination would antedate that; that is, the symptoms obtained, according to my examinations, included that—the symptoms of the mental disorder.

court failed to produce any retraction of Dr. Gilbert's testimony that the "period of insanity would have embraced the date July 13, 1951." And though the prosecution sought unsuccessfully in its cross- and recross-examination of Dr. Gilbert to establish that Durham was a malingerer who feigned insanity whenever he was trapped for his misdeeds, it failed to present any expert testimony to support this theory. In addition to Dr. Gilbert's testimony, there was testimony by Durham's mother to the effect that in the interval between his discharge from St. Elizabeths in May 1951, and the crime "he seemed afraid of people" and had urged her to put steel bars on his bedroom windows.

Apparently the trial judge regarded this psychiatric testimony as "no testimony" on two grounds: (1) it did not adequately cover Durham's condition on July 13, 1951, the date of the offense; and (2) it was not directed to Durham's capacity to distinguish between right and wrong. We are unable to agree that for either of these reasons the psychiatric testimony could properly be considered "no testimony."

(1) Following Dr. Gilbert's testimony that the condition in which he found Durham on September 3, 1951 was progressive and did not "arrive overnight," Dr. Gilbert responded to a series of questions by the court:

"Q [COURT]. Then is it reasonable to assume that it is not possible to determine *how far* this state of unsound mind had progressed by July 13th? Isn't that so?

"A [DR. GILBERT]. As to the seriousness of the symptoms as compared with them and the time I observed him, that's true, except that his travels were based, according to his statement to me, on certain of the symptoms and his leaving Washington, his giving up his job and work and leaving the work that he had tried to do.

"Q. But you can't tell, can you, *how far* those symptoms had progressed and become worse by the 13th of July?

"A. No, not *how far* they were, that is correct." [Emphasis supplied.]

Thereafter, when the prosecutor on recross asked Dr. Gilbert whether he would change his opinion concerning Durham's mental condition on July 13, 1951, if he

"Q. Can you tell us what symptoms you found, Doctor?

"A. Well, he was trying to work for a while, he stated, and while he was working at one of these People's Drug Stores he began to hear false voices and suffer from hallucinations and believed that the other employees and others in the store talked about him, watched him, and the neighbors did the same, watching him from their windows, talking about him, and those symptoms continued and were present through the time that I examined him in September and October.

"Q [Mr. McLaughlin]. You were asked the specific question, Doctor, whether or not in your opinion on July 13, 1951, this defendant was of unsound mind and didn't know the difference between right and wrong. Can you express an opinion as to that?

"A. Yes. It is my opinion he was of unsound mind."

(4) "Q [Mr. McLaughlin]. Can you tell us—this is for my own information, I would like to know this—you say that this defendant, at the time you examined him in 1951 was of unsound mind and had been of unsound mind sometime prior to that; is that your statement?

"A. Yes, sir.

"Q. Can you tell us how long prior to that time he was of unsound mind?

"A. Well, while he was working in People's Drug Store the symptoms were present, and how long before that, I didn't get the date of that.

"Q. When was he working in People's Drug Store?

"A. Sometime after his discharge from Saint Elizabeths Hospital.

"Q. In 1947?

"A. Oh, no; 1951."

knew that Durham had been released from St. Elizabeths just two months before as being of sound mind, the court interrupted to say: "Just a minute. The Doctor testified in answer to my question that he doesn't know and he can't express a definite opinion as to his mental condition on the 13th of July." This, we think, overlooks the witness' unequivocal testimony on direct and cross-examination,¹¹ and misconceives what he had said in response to questioning by the court, namely, that certain symptoms of mental disorder antedated the crime, although it was impossible to say how far they had progressed.

Moreover, any conclusion that there was "no testimony" regarding Durham's mental condition at the time of the crime disregards the testimony of his mother. Her account of his behavior after his discharge from St. Elizabeths in May 1951 was directly pertinent to the issue of his sanity at the time of the crime.

(2) On re-direct examination, Dr. Gilbert was asked whether he would say that Durham "knew the difference between right and wrong on July 13, 1951; that is, his ability to distinguish between what was right and what was wrong." He replied: "As I have stated before, if the question of the right and wrong were propounded to him he could give you the right answer." Then the court interrupted to ask:

"The Court. No, I don't think that is the question, Doctor—not whether he could give a right answer to a question, but whether he, himself, knew the difference between right and wrong in connection with governing his own actions. * * * If you are unable to answer, why, you can say so; I mean, if you are unable to form an opinion.

"The Witness. I can only answer this way: That I can't tell how much the abnormal thinking and the abnormal experiences in the form of hallucinations and delusions—delusions of persecution—had to do with his anti-social behavior.

"I don't know how anyone can answer that question categorically, except as one's experience leads him to know that most mental cases can give you a categorical answer of right and wrong, but what influence these symptoms have on abnormal behavior or antisocial behavior—

"The Court. Well, your answer is that you are unable to form an opinion, is that it?

"The Witness. I would say that that is essentially true, for the reasons that I have given."

Later, when defense counsel sought elaboration from Dr. Gilbert on his answers relating to the "right and wrong" test, the court cut off the questioning with the admonition that "you have answered the question, Doctor."

The inability of the expert to give categorical assurance that Durham was unable to distinguish between right and wrong did not destroy the effect of his previous testimony that the period of Durham's "insanity" embraced July 13, 1951. It is plain from our decision in *Tatum* that this previous testimony was adequate to prevent the presumption of sanity from becoming conclusive and to place the burden of proving sanity upon the Government. None of the testimony before the court in *Tatum* was couched in terms of "right and wrong."

Finally, even assuming *arguendo* that the court, contrary to the plain meaning of its words, recognized that the prosecution had the burden of proving Durham's sanity, there would still be a fatal error. For once the issue of insanity is raised by the introduction of "some evidence," so that the presumption of sanity is no longer absolute, it is incumbent upon the trier of fact to weigh and consider "the whole evidence, including that supplied by the presumption of sanity * * *" on the issue of "the capacity in law of the accused to commit" the crime.¹² Here,

¹¹ See note 10, *supra*.

¹² *Davis v. United States*, 160 U.S. 469, 488 (1895).

manifestly, the court as the trier of fact did not and could not weigh "the whole evidence," for it found there was "no testimony concerning the mental state" of Durham.

For the foregoing reasons, the judgment is reversed and the case is remanded for a new trial.

II

It has been ably argued by counsel for Durham that the existing tests in the District of Columbia for determining criminal responsibility, *i.e.*, the so-called right-wrong test supplemented by the irresistible impulse test, are not satisfactory criteria for determining criminal responsibility. We are urged to adopt a different test to be applied on the retrial of this case. This contention has behind it nearly a century of agitation for reform.

A. The right-wrong test, approved in this jurisdiction in 1882,¹³ was the exclusive test of criminal responsibility in the District of Columbia until 1929 when we approved the irresistible impulse test as a supplementary test in *Smith v. United States*.¹⁴ The right-wrong test has its roots in England. There, by the first quarter of the eighteenth century, an accused escaped punishment if he could not distinguish "good and evil," *i.e.*, if he "doth not know what he is doing, no more than * * * a wild beast."¹⁵ Later in the same century, the "wild beast" test was abandoned and "right and wrong" was substituted for "good and evil."¹⁶ And toward the middle of the nineteenth century, the House of Lords in the famous *M'Naghten* case¹⁷ restated what had become the accepted "right-wrong" test¹⁸ in a form which has since been followed, not only in England¹⁹ but in most American jurisdictions²⁰ as an exclusive test of criminal responsibility:

"* * * the jurors ought to be told in all cases that every man is to be presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfac-

¹³ 12 D.C.Sup.Ct. (1 Mackey) 498, 550 (1882). The right-wrong test was reaffirmed in *United States v. Lee*, 15 D.C.Sup.Ct. (4 Mackey) 489, 496 (1886).

¹⁴ 59 App.D.C. 144, 36 F.2d 548 (1929).

¹⁵ GLUECK, *MENTAL DISORDER AND THE CRIMINAL LAW* 138-39 (1925), citing *Rex v. Arnold*, 16 How.St.Tr. 695, 764 (1724).

¹⁶ *Id.* at 142-52, citing *Earl Ferrer's case*, 19 How.St.Tr. 886 (1760). One writer has stated that these tests originated in England in the 13th or 14th century, when the law began to define insanity in terms of intellect for purposes of determining capacity to manage feudal estates. Comment, *Lunacy and Idiocy—The Old Law and Its Incubus*, 18 U. OF CHI. L.REV. 361 (1951).

¹⁷ 8 Eng.Rep. 718 (1843).

¹⁸ HALL, *PRINCIPLES OF CRIMINAL LAW* 480, n. 6 (1947).

¹⁹ ROYAL COMMISSION ON CAPITAL PUNISHMENT 1949-1953 REPORT (Cmd. 8932) 79 (1953) (hereinafter cited as ROYAL COMMISSION REPORT).

²⁰ *Weihsien, The M'Naghten Rule in Its Present Day Setting*, FEDERAL PROBATION 8 (Sept. 1953); *Weihsien, Insanity as a Defense in Criminal Law* 15, 64-68, 109-47 (1933); *Leland v. Oregon*, 343 U.S. 790, 800 (1952).

"In five States the M'Naghten Rules have been in substance re-enacted by statute." ROYAL COMMISSION REPORT 409; see, *e.g.*, "Sec. 1120 of the [New York State] Penal Law [which] provides that a person is not excused from liability on the grounds of insanity, idiocy or imbecility, except upon proof that at the time of the commission of the criminal act he was laboring under such a defect of reason as (1) not to know the nature and quality of the act he was doing or (2) not to know that the act was wrong." *Ploscowe, Suggested Changes in the New York Laws and Procedures Relating to the Criminally Insane and Mentally Defective Offenders*, 43 J.CRIM.L., CRIMINOLOGY & POLICE SCI. 312, 314 (1952).

tion; and that, to establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong." 21

As early as 1838, Isaac Ray, one of the founders of the American Psychiatric Association, in his now classic *MEDICAL JURISPRUDENCE OF INSANITY*, called knowledge of right and wrong a "fallacious" test of criminal responsibility.²² This view has long since been substantiated by enormous developments in knowledge of mental life.²³ In 1928 Mr. Justice Cardozo said to the New York Academy of Medicine: "Everyone concedes that the present [legal] definition of insanity has little relation to the truths of mental life."²⁴

Medico-legal writers in large number,²⁵ *THE REPORT OF THE ROYAL COMMISSION ON CAPITAL PUNISHMENT 1949-1953*,²⁶ and *THE PRELIMINARY REPORT BY THE COMMITTEE ON FORENSIC PSYCHIATRY OF THE GROUP FOR THE ADVANCEMENT OF PSYCHIATRY*²⁷ present convincing evidence that the right-and-wrong test is "based

²¹ 8 Eng.Rep. 718, 722 (1843). "Today, Oregon is the only state that requires the accused, on a plea of insanity, to establish that defense beyond a reasonable doubt. Some twenty states, however, place the burden on the accused to establish his insanity by a preponderance of the evidence or some similar measure of persuasion." *Leland v. Oregon*, *supra* note 20, at 798. Since *Davis v. United States*, 160 U.S. 469, 484 (1895), a contrary rule of procedure has been followed in the Federal courts. For example, in compliance with *Davis*, we held in *Tatum v. United States*, *supra* note 8 and text, "as soon as 'some evidence of mental disorder is introduced, * * * sanity, like any other fact, must be proved as part of the prosecution's case beyond a reasonable doubt.'"

²² RAY, *MEDICAL JURISPRUDENCE OF INSANITY* 47 and 34 *et seq.* (1st ed. 1838). "That the insane mind is not entirely deprived of this power of moral discernment, but in many subjects is perfectly rational, and displays the exercise of a sound and well balanced mind is one of those facts now so well established, that to question it would only betray the height of ignorance and presumption." *Id.* at 32.

²³ See Zilboorg, *Legal Aspects of Psychiatry in ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY 1844-1944* 507, 552 (1944).

²⁴ CARDOZO, *WHAT MEDICINE CAN DO FOR THE LAW* 32 (1930).

²⁵ For a detailed bibliography on Insanity as a Defense to Crime, see 7 *THE RECORD OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK* 158-62 (1952). And see, e.g., ALEXANDER, *THE CRIMINAL, THE JUDGE AND THE PUBLIC* 70 *et seq.* (1931); CARDOZO, *WHAT MEDICINE CAN DO FOR THE LAW* 28 *et seq.* (1930); CLECKLEY, *THE MASK OF SANITY* 491 *et seq.* (2d ed. 1950); DEUTSCH, *THE MENTALLY ILL IN AMERICA* 389-417 (2d ed. 1949); GLUECK, *MENTAL DISORDER AND THE CRIMINAL LAW* (1925), *CRIME AND JUSTICE* 96 *et seq.* (1936); GUTTMACHER & WEIHOFEN, *PSYCHIATRY AND THE LAW* 218, 403-23 (1952); HALL, *PRINCIPLES OF CRIMINAL LAW* 477-538 (1947); MENNINGER, *THE HUMAN MIND* 450 (1937); Hall & Menninger, "Psychiatry and the Law"—*A Dual Review*, 38 *IOWA L.REV.* 687 (1953); OVERHOLSER, *THE PSYCHIATRIST AND THE LAW* 41-43 (1953); OVERHOLSER & RICHMOND, *HANDBOOK OF PSYCHIATRY* 208-15 (1947); Ploscowe, *Suggested Changes in the New York Laws and Procedures Relating to the Criminally Insane and Mentally Defective Offenders*, 43 *J.CRIM.L., CRIMINOLOGY & POLICE SCI.* 312, 314 (1952); RAY, *MEDICAL JURISPRUDENCE OF INSANITY* (1st ed. 1838) (4th ed. 1860); Reik, *The Doe-Ray Correspondence: A Pioneer Collaboration in the Jurisprudence of Mental Disease*, 63 *YALE L.J.* 183 (1953); WEIHOFEN, *INSANITY AS A DEFENSE IN CRIMINAL LAW* (1933), *The M'Naghten Rule in Its Present Day Setting*, *FEDERAL PROBATION* 8 (Sept. 1953); ZILBOORG, *MIND, MEDICINE AND MAN* 246-97 (1943), *Legal Aspects of Psychiatry, AMERICAN PSYCHIATRY 1844-1944* 507 (1944).

²⁶ ROYAL COMMISSION REPORT 73-129.

²⁷ The Committee on Forensic Psychiatry (whose report is hereinafter cited as *GAP REPORT*) was composed of Drs. Philip Q. Roche, Frank S. Curran, Lawrence Z. Freedman and Manfred S. Guttmacher. They were assisted in their deliberations by leading psychiatrists, jurists, law professors, and legal practitioners.

on an entirely obsolete and misleading conception of the nature of insanity."²⁸ The science of psychiatry now recognizes that a man is an integrated personality and that reason, which is only one element in that personality, is not the sole determinant of his conduct. The right-wrong test, which considers knowledge or reason alone, is therefore an inadequate guide to mental responsibility for criminal behavior. As Professor Sheldon Glueck of the Harvard Law School points out in discussing the right-wrong tests, which he calls the knowledge tests:

"It is evident that the knowledge tests unscientifically abstract out of the mental make-up but one phase or element of mental life, the cognitive, which, in this era of dynamic psychology, is beginning to be regarded as not the most important factor in conduct and its disorders. In brief, these tests proceed upon the following questionable assumptions of an outworn era in psychiatry: (1) that lack of knowledge of the 'nature or quality' of an act (assuming the meaning of such terms to be clear), or incapacity to know right from wrong, is the sole or even the most important symptom of mental disorder; (2) that such knowledge is the sole instigator and guide of conduct, or at least the most important element therein, and consequently should be the sole criterion of responsibility when insanity is involved; and (3) that the capacity of knowing right from wrong can be completely intact and functioning perfectly even though a defendant is otherwise demonstrably of disordered mind."²⁹

Nine years ago we said:

"The modern science of psychology * * * does not conceive that there is a separate little man in the top of one's head called reason whose function it is to guide another unruly little man called instinct, emotion, or impulse in the way he should go."³⁰

By its misleading emphasis on the cognitive, the right-wrong test requires court and jury to rely upon what is, scientifically speaking, inadequate, and most often, invalid³¹ and irrelevant testimony in determining criminal responsibility.³²

²⁸ ROYAL COMMISSION REPORT 80.

²⁹ Glueck, *Psychiatry and the Criminal Law*, 12 MENTAL HYGIENE 575, 580 (1928), as quoted in DEUTSCH, *THE MENTALLY ILL IN AMERICA* 396 (2d ed. 1949); and see, e.g., MENNINGER, *THE HUMAN MIND* 450 (1937); GUTTMACHER & WEIHOFEN, *PSYCHIATRY AND THE LAW* 403-08 (1952).

³⁰ *Holloway v. United States*, 80 U.S.App.D.C. 3, 5, 148 F.2d 665, 667 (1945), cert. denied, 334 U.S. 852 (1948).

More recently, the Royal Commission, after an exhaustive survey of legal, medical and lay opinion in many Western countries, including England and the United States, made a similar finding. It reported:

"The gravamen of the charge against the M'Naghten Rules is that they are not in harmony with modern medical science, which, as we have seen, is reluctant to divide the mind into separate compartments—the intellect, the emotions and the will—but looks at it as a whole and considers that insanity distorts and impairs the action of the mind as a whole." ROYAL COMMISSION REPORT 115.

The Commission lends vivid support to this conclusion by pointing out that "It would be impossible to apply modern methods of care and treatment in mental hospitals, and at the same time to maintain order and discipline, if the great majority of the patients, even among the grossly insane, did not know what is forbidden by the rules and that, if they break them, they are liable to forfeit some privilege. Examination of a number of individual cases in which a verdict of guilty but insane [the nearest English equivalent of our acquittal by reason of insanity] was returned, and rightly returned, has convinced us that there are few indeed where the accused can truly be said not to have known that his act was wrong." *Id.* at 103.

³¹ See GUTTMACHER & WEIHOFEN, *PSYCHIATRY AND THE LAW* 421, 422 (1952). The M'Naghten rules "constitute not only an arbitrary restriction on vital medi-

The fundamental objection to the right-wrong test, however, is not that criminal irresponsibility is made to rest upon an inadequate, invalid or indeterminable symptom or manifestation, but that it is made to rest upon *any* particular symptom.³³ In attempting to define insanity in terms of a symptom, the courts have assumed an impossible role,³⁴ not merely one for which they have no special competence.³⁵ As the Royal Commission emphasizes, it is dangerous "to abstract particular mental faculties, and to lay it down that unless these particular faculties are destroyed or gravely impaired, an accused person, whatever the nature of his mental disease, must be held to be criminally responsible * * *"³⁶ In this field of law as in others, the fact finder should be free to consider all information advanced by relevant scientific disciplines.³⁷

Despite demands in the name of scientific advances, this court refused to alter the right-wrong test at the turn of the century.³⁸ But in 1929, we reconsidered in response to "the cry of scientific experts" and added the irresistible impulse test as a supplementary test for determining criminal responsibility. Without "hesitation" we declared, in *Smith v. United States*, "it to be the law of this

cal data, but also impose an improper onus of decision upon the expert witness. The Rules are unanswerable in that they have no consensus with established psychiatric criteria of symptomatic description save for the case of disturbed consciousness or of idiocy, * * *." From statement by Dr. Philip Q. Roche, quoted *id.* at 407. See also *United States v. Baldi*, 192 F.2d 540, 567 (dissenting opinion) (3d Cir. 1951).

³² In a very recent case, the Supreme Court of New Mexico recognized the inadequacy of the right-wrong test, and adopted what it called an "extension of the M'Naghten Rules." Under this extension, lack of knowledge of right and wrong is not essential for acquittal "if, by reason of disease of the mind, defendant has been deprived of or lost the power of his will * * *." *State v. White*, No. 5724, decided May 12, 1954, 22 U.S.L. WEEK 2559.

³³ DEUTSCH, *THE MENTALLY ILL IN AMERICA* 400 (2d ed. 1949); Keedy, *Irresistible Impulse as a Defense in Criminal Law*, 100 U. OF PA.L.REV. 956, 992 (1952).

³⁴ Professor John Whitehorn of the Johns Hopkins Medical School, who recently prepared an informal memorandum on this subject for a Commission on Legal Psychiatry appointed by the Governor of Maryland, has said: "Psychiatrists are challenged to set forth a crystal-clear statement of what constitutes insanity. It is impossible to express this adequately in words, alone, since such diagnostic judgments involve clinical skill and experience which cannot wholly be verbalized. * * * The medical profession would be baffled if asked to write into the legal code universally valid criteria for the diagnosis of the many types of psychotic illness which may seriously disturb a person's responsibility, and even if this were attempted, the diagnostic criteria would have to be rewritten from time to time, with the progress of psychiatric knowledge." Quoted in GUTTMACHER & WEIHOFEN, *PSYCHIATRY AND THE LAW* 419-20 (1952).

³⁵ " * * * the legal profession were invading the province of medicine, and attempting to install old exploded medical theories in the place of facts established in the progress of scientific knowledge." *State v. Pike*, 49 N.H. (1 Shirley) 399, 438 (1870).

³⁶ ROYAL COMMISSION REPORT 114. And see *State v. Jones*, 50 N.H. (2 Shirley) 369, 392-93 (1871).

³⁷ Keedy, *Irresistible Impulse as a Defense in Criminal Law*, 100 U. OF PA.L. REV. 956, 992-93 (1952).

³⁸ See, e.g., *Taylor v. United States*, 7 App.D.C. 27, 41-44 (1895), where we rejected "emotional insanity" as a defense, citing with approval the following from the trial court's instruction to the jury: "Whatever may be the cry of scientific experts, the law does not recognize, but condemns the doctrine of emotional insanity—that a man may be sane up until a moment before he commits a crime, insane while he does it, and sane again soon afterwards. Such a doctrine would be dangerous in the extreme. The law does not recognize it; and a jury cannot without violating their oaths." This position was emphatically reaffirmed in *Snell v. United States*, 16 App.D.C. 501, 524 (1900).

District that, in cases where insanity is interposed as a defense, and the facts are sufficient to call for the application of the rule of irresistible impulse, the jury should be so charged."³⁹ We said:

" * * * The modern doctrine is that the degree of insanity which will relieve the accused of the consequences of a criminal act must be such as to create in his mind an uncontrollable impulse to commit the offense charged. This impulse must be such as to override the reason and judgment and obliterate the sense of right and wrong to the extent that the accused is deprived of the power to choose between right and wrong. The mere ability to distinguish right from wrong is no longer the correct test either in civil or criminal cases, where the defense of insanity is interposed. The accepted rule in this day and age, with the great advancement in medical science as an enlightening influence on this subject, is that the accused must be capable, not only of distinguishing between right and wrong, but that he was not impelled to do the act by an irresistible impulse, which means before it will justify a verdict of acquittal that his reasoning powers were so far dethroned by his diseased mental condition as to deprive him of the will power to resist the insane impulse to perpetrate the deed, though knowing it to be wrong."⁴⁰

As we have already indicated, this has since been the test in the District.

Although the *Smith* case did not abandon the right-wrong test, it did liberate the fact finder from exclusive reliance upon that discredited criterion by allowing the jury to inquire also whether the accused suffered from an undefined "diseased mental condition [which] deprive[d] him of the will power to resist the insane impulse * * *."⁴¹ The term "irresistible impulse," however, carries the misleading implication that "diseased mental condition[s]" produce only sudden, momentary or spontaneous inclinations to commit unlawful acts.⁴² As the Royal Commission found:

" * * * In many cases * * * this is not true at all. The sufferer from [melancholia, for example] experiences a change of mood which alters the whole of his existence. He may believe, for instance, that a future of such degradation and misery awaits both him and his family that death for all is a less dreadful alternative. Even the thought that the acts he contemplates are murder and suicide pales into insignificance in contrast with what he otherwise expects. The criminal act, in such circumstances, may be the reverse of impulsive. It may be coolly and carefully prepared; yet it is still the act of a madman. This is merely an illustration; similar states of mind are likely to lie behind the criminal act when murders are committed by persons suffering from schizophrenia or paranoid psychoses due to disease of the brain."⁴³

³⁹ 59 App.D.C. 144, 146, 36 F.2d 548, 550 (1929).

⁴⁰ 59 App.D.C. at 145, 36 F.2d at 549.

⁴¹ 59 App.D.C. at 145, 36 F.2d at 549.

⁴² Impulse, as defined by WEBSTER'S NEW INTERNATIONAL DICTIONARY (2d ed. 1950), is:

"1. Act of impelling, or driving onward with sudden force; impulsion, esp. force so communicated as to produce motion suddenly, or immediately * * *.

"2. An incitement of the mind or spirit, esp. in the form of an abrupt and vivid suggestion, prompting some unpremeditated action or leading to unforeseen knowledge or insight; a spontaneous inclination * * *.

"3. * * * motion produced by a sudden or momentary force * * *." [Emphasis supplied.]

⁴³ ROYAL COMMISSION REPORT 110; for additional comment on the irresistible impulse test, see GLUECK, CRIME AND JUSTICE 101-03 (1936); GUTTMACHER & WEIHOFFEN, PSYCHIATRY AND THE LAW 410-12 (1952); HALL, GENERAL PRINCIPLES OF CRIMINAL LAW 505-26 (1947); Keedy, *Irresistible Impulse as a Defense in Criminal Law*, 100 U. OF PA.L.REV. 956 (1952); WERTHAM, THE SHOW OF VIOLENCE 14 (1949).

The New Mexico Supreme Court in recently adopting a broader criminal insanity rule (note 32, *supra*) observed: " * * * insanity takes the form of the personality

We find that as an exclusive criterion the right-wrong test is inadequate in that (a) it does not take sufficient account of psychic realities and scientific knowledge, and (b) it is based upon one symptom and so cannot validly be applied in all circumstances. We find that the "irresistible impulse" test is also inadequate in that it gives no recognition to mental illness characterized by brooding and reflection and so relegates acts caused by such illness to the application of the inadequate right-wrong test. We conclude that a broader test should be adopted.⁴⁴

B. In the District of Columbia, the formulation of tests of criminal responsibility is entrusted to the courts⁴⁵ and, in adopting a new test, we invoke our inherent power to make the change prospectively.⁴⁶

The rule we now hold must be applied on the retrial of this case and in future cases is not unlike that followed by the New Hampshire court since 1870.⁴⁷ It is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect.⁴⁸

We use "disease" in the sense of a condition which is considered capable of either improving or deteriorating. We use "defect" in the sense of a condition which is not considered capable of either improving or deteriorating and which may be either congenital, or the result of injury, or the residual effect of a physical or mental disease.

Whenever there is "some evidence" that the accused suffered from a diseased or defective mental condition at the time the unlawful act was committed, the trial court must provide the jury with guides for determining whether the accused can be held criminally responsible. We do not, and indeed could not, formulate an

of the individual and, if his tendency is toward depression, his wrongful act may come at the conclusion of a period of complete lethargy, thoroughly devoid of excitement."

⁴⁴ "As we recently said, * * * former common law should not be followed where changes in conditions have made it obsolete. We have never hesitated to exercise the usual judicial function of revising and enlarging the common law." *Linkins v. Protestant Episcopal Cathedral Foundation*, 87 U.S.App.D.C. 351, 355, 187 F.2d 357, 361 (1950). Cf. *Funk v. United States*, 290 U.S. 371, 381-82 (1933).

⁴⁵ Congress, like most State legislatures, has never undertaken to define insanity in this connection, although it recognizes the fact that an accused may be acquitted by reason of insanity. See D. C. CODE § 24-301 (1951). And as this court made clear in *Hill v. United States*, Congress has left no doubt that "common-law procedure, in all matters relating to crime * * * still continues in force here in all cases except where special provision is made by statute to the exclusion of the common-law procedure." 22 App. D.C. 395, 401 (1903), and statutes cited therein; *Linkins v. Protestant Episcopal Cathedral Foundation*, 87 U.S.App.D.C. at 354-55, 187 F.2d at 360-61; and see *Fisher v. United States*, 328 U. S. 463 (1946).

⁴⁶ See *Great Northern Ry. v. Sunburst Co.*, 287 U.S. 358 (1932); *National Labor Relations Board v. Guy F. Atkinson Co.*, 195 F.2d 141, 148 (9th Cir. 1952); Concurring opinion of Judge Frank in *Aero Spark Plug Co. v. B. G. Corporation*, 130 F.2d 290, 298, and n. 24 (2d Cir. 1942); *Warring v. Colpoys*, 74 App.D.C. 303, —, 122 F.2d 642, 645 (1941); *Moore & Oglebay, The Supreme Court, Stare Decisis and Law of the Case*, 21 TEXAS L.REV. 514, 535 (1943); *Carpenter, Court Decisions and the Common Law*, 17 COL.L.REV. 593, 606-07 (1917). But see *von Moschizker, Stare Decisis in Courts of Last Resort*, 37 HARV. L.REV. 409, 426 (1924). Our approach is similar to that of the Supreme Court of California in *People v. Maughs*, 149 Cal. 253, 86 P. 187, 191 (1906), where the court prospectively invalidated a previously accepted instruction, saying:

"* * * we think the time has come to say that in all future cases which shall arise, and where, after this warning, this instruction shall be given, this court will hold the giving of it to be so prejudicial to the rights of a defendant, secured to him by our Constitution and laws, as to call for the reversal of any judgment which may be rendered against him."

⁴⁷ *State v. Pike*, 49 N.H. (1 Shirley) 399 (1870).

⁴⁸ Cf. *State v. Jones*, 50 N.H. (2 Shirley) 369, 398 (1871).

instruction which would be either appropriate or binding in all cases. But under the rule now announced, any instruction should in some way convey to the jury the sense and substance of the following: If you the jury believe beyond a reasonable doubt that the accused was not suffering from a diseased or defective mental condition at the time he committed the criminal act charged, you may find him guilty. If you believe he was suffering from a diseased or defective mental condition when he committed the act, but believe beyond a reasonable doubt that the act was not the product of such mental abnormality, you may find him guilty. Unless you believe beyond a reasonable doubt either that he was not suffering from a diseased or defective mental condition, or that the act was not the product of such abnormality, you must find the accused not guilty by reason of insanity. Thus your task would not be completed upon finding, if you did find, that the accused suffered from a mental disease or defect. He would still be responsible for his unlawful act if there was no causal connection between such mental abnormality and the act.⁴⁹ These questions must be determined by you from the facts which you find to be fairly deducible from the testimony and the evidence in this case.⁵⁰

The questions of fact under the test we now lay down are as capable of determination by the jury as, for example, the questions juries must determine upon a claim of total disability under a policy of insurance where the state of medical knowledge concerning the disease involved, and its effects, is obscure or in conflict. In such cases, the jury is not required to depend on arbitrarily selected "symptoms, phases or manifestations"⁵¹ of the disease as criteria for determining the ultimate questions of fact upon which the claim depends. Similarly, upon a claim of criminal irresponsibility, the jury will not be required to rely on such symptoms as criteria for determining the ultimate question of fact upon which such claim depends. Testimony as to such "symptoms, phases or manifestations," along with other relevant evidence, will go to the jury upon the ultimate questions of fact which it alone can finally determine. Whatever the state of psychiatry, the psychiatrist will be permitted to carry out his principal court function which, as we noted in *Holloway*, "is to inform the jury of the character of [the accused's] mental disease [or defect]."⁵² The jury's range of inquiry will not be limited to, but may include, for example, whether an accused, who suffered from a mental disease or defect, did not know the difference between right and wrong, acted under the compulsion of an irresistible impulse, or had "been deprived of or lost the power of his will * * *."⁵³

⁴⁹ "There is no *a priori* reason why every person suffering from any form of mental abnormality or disease, or from any particular kind of mental disease, should be treated by the law as not answerable for any criminal offence which he may commit, and be exempted from conviction and punishment. Mental abnormalities vary infinitely in their nature and intensity and in their effects on the character and conduct of those who suffer from them. Where a person suffering from a mental abnormality commits a crime, there must always be some likelihood that the abnormality has played some part in the causation of the crime; and generally speaking, the graver the abnormality, * * * the more probable it must be that there is a causal connection between them. But the closeness of this connection will be shown by the facts brought in evidence in individual cases and cannot be decided on the basis of any general medical principle." ROYAL COMMISSION REPORT 99.

⁵⁰ The court may always, of course, if it deems it advisable for the assistance of the jury, point out particular areas of agreement and conflict in the expert testimony in each case, just as it ordinarily does in summing up any other testimony.

⁵¹ *State v. Jones*, 50 N.H. (2 Shirley) 368, 398 (1871).

⁵² 80 U.S.App.D.C. 3, 5, 148 F.2d 665, 667 (1945).

⁵³ *State v. White*, see n. 32, *supra*.

Finally, in leaving the determination of the ultimate question of fact to the jury, we permit it to perform its traditional function which, as we said in *Holloway*, is to apply "our inherited ideas of moral responsibility to individuals prosecuted for crime * * *."⁵⁴ Juries will continue to make moral judgments, still operating under the fundamental precept that "Our collective conscience does not allow punishment where it cannot impose blame."⁵⁵ But in making such judgments, they will be guided by wider horizons of knowledge concerning mental life. The question will be simply whether the accused acted because of a mental disorder, and not whether he displayed particular symptoms which medical science has long recognized do not necessarily, or even typically, accompany even the most serious mental disorder.⁵⁶

The legal and moral traditions of the western world require that those who, of their own free will and with evil intent (sometimes called *mens rea*), commit acts which violate the law, shall be criminally responsible for those acts. Our traditions also require that where such acts stem from and are the product of a mental disease or defect as those terms are used herein, moral blame shall not attach, and hence there will not be criminal responsibility.⁵⁷ The rule we state in this opinion is designed to meet these requirements.

Reversed and remanded for a new trial.

⁵⁴ 80 U.S.App.D.C. at 5, 148 F.2d at 667.

⁵⁵ 80 U.S.App.D.C. at 4-5, 148 F.2d at 666-67.

⁵⁶ See text, *supra*, pp. 311-13.

⁵⁷ An accused person who is acquitted by reason of insanity is presumed to be insane, *Orencia v. Overholser*, 82 U.S.App.D.C. 285, 163 F.2d 763 (1947); *Barry v. White*, 62 App.D.C. 69, 64 F.2d 707 (1933), and may be committed for an indefinite period to a "hospital for the insane." D. C. Code § 24-301 (1951).

We think that even where there has been a specific finding that the accused was competent to stand trial and to assist in his own defense, the court would be well advised to invoke this Code provision so that the accused may be confined as long as "the Public Safety and * * * [his] welfare" require. *Barry v. White*, 62 App.D.C. at 71, 64 F.2d at 709.

BOOK REVIEWS

MOTIVATION AND PERSONALITY. By A. H. Maslow. New York, Harper and Brothers, 1954. pp. xiv + 411.

Most of us who are students of psychology from time to time experience deep misgivings about the status and development of our science. Much of the writing in the field is a statement in other terms of principles often stated before. Research is all too frequently a substantiation of the obvious or a demonstration of virtuosity in technique applied to problems of little meaning. Most disturbing of all, that which has been discovered or claimed as a discovery is strangely feeble in the presence of urgent and vexing problems of human life: education, human relations, personal happiness, general health remain little affected by the science which should contribute most to them. This situation in the case of an area of study which actually and by implication promised so much for mankind baffles the intellect and frustrates the most basic longings of the sincere scientist, especially if he has strong humanistic tendencies.

I first taught a course in mental hygiene in the Duke University summer school of 1932. I was then pursuing advanced graduate study at Duke under the guidance of William McDougall, William A. Brownell, William Stern, Donald Adams, Karl Zener, Howard Easley, J. B. Rhine, and others of the Duke staff of that day. These men represented the major schools of psychology in all their variety which were then at the height of their intensity. The private discussion sessions of graduate students were, to say the least, interesting for they reflected the hopes, fears, and deep doubts of these young men who had dedicated themselves to psychology as a science. There was an underlying uneasiness (which in many cases has probably lingered these twenty-odd intervening years) that there was something seriously wrong with psychology, that for some reason or group of reasons it was off on the wrong foot. I have taught one or more courses in mental hygiene and related subjects at the college and university level each year since that time.

These personal things are mentioned because these factors, including a steadily developing frame of mind and a continuing sense of something wrong, were the background from which A. H. Maslow's *Motivation and Personality* was examined. In my judgment, this book is the most important volume I have seen in this field in a good ten years or longer. Although many of the ideas in some of the chapters

have previously appeared in the journal literature under the authorship of Maslow and his associates, and related ideas have been developing for many years, the book presents a coherent theory with some substantiating research of utmost significance.

As the title indicates, the core of the book is Maslow's theory of human motivation and the meaning of that theory for personality, especially for the development of healthy personality. The volume is, therefore, an excellent treatise on mental hygiene. It should be an extremely useful text for upper division and graduate courses on personality and mental health, especially because of its happy combination of clarity, depth, and suggestiveness.

How does the author tackle this vital subject? First, there are two very hard-hitting chapters on the nature of science as it relates to the very special subject called "psychology." The third chapter contends persuasively for a "holistic-dynamic theory" as the most productive approach to the study of personality. Chapters IV, V, and VI state Maslow's fascinating theory of motivation, including his suggestive conception of the hierarchal organization of the basic human needs and the central aspects of need gratification. Chapters VII to XVII discuss the implications of this theory for personality organization and health. Chapters XII ("Self-Actualizing People: A Study of Psychological Health") and XVI ("Psychotherapy, Health, and Motivation") are two of the finest chapters on mental hygiene I have seen in more than twenty years of steady reading on the subject. Finally, Chapter XVIII entitled "Toward a Positive Psychology" (and the Appendix) offers very stimulating suggestions for a more rewarding approach to the study of psychology. The author believes that the whole field has been tragically limited and distorted by a predominant preoccupation with pathology to the neglect of the nature of healthy function.

Are there no criticisms of the book? Three may be mentioned: (1) As the author so honestly states in his preface, the book is incomplete:

I must warn the reader that this book presents only a portion of the systematic psychology I have prepared. As it stands, it presents too rosy and optimistic a picture of human nature. Particularly conspicuous is the omission of a chapter on the limitations imposed on individual basic-need-gratification by the fact that other individuals also have legitimate needs. I had planned to discuss in this chapter the problems of discipline, enculturation, harmful permissiveness, and the strengthening effects of delay and of frustration, conflict, and deprivation. I had also planned chapters on the problem of evil, and on the nature of psychological illness. If these chapters had been finished in time, the picture of

human nature presented in this book would have been much more inclusive and realistic. (pp. xiii-xiv)

But surely such completeness is a high level of aspiration for this complex subject. It is good to hope a second volume will follow before too long.

(2) It seems to me the author has allowed the "bath water" of much that has composed organized religion in the history of man to obscure for him and his excellent theory the "baby" that is the essence of a high spiritual religion at its best. The author is in no sense antagonistic to religion and spiritual values but may have a small blind spot for their more creative potential for personality growth and health.

(3) Many will feel that the book is too theoretical—that its author is too free to hypothesize. He does often go far beyond the generalization warranted by research already done. Nearly every page states one or more hypotheses that need to be tested. To me this is one of the great strengths of the book, but others will condemn this venture-some tendency.

The style of the book is fresh and makes for pleasant reading. There is a good bibliography and index. The book is highly recommended to all serious students of personality and mental hygiene.

Perhaps it should be added that Maslow is severely critical of much of the behavior, approach, and attitude of the current psychological fraternity, and hence many of his colleagues may find his book distasteful medicine.

E. V. PULLIAS

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Los Angeles, Calif.*

THE CHILD, HIS PARENTS AND THE NURSE. By Florence G. Blake. Philadelphia, J. B. Lippincott Co., 1954. 440 p.

Miss Blake is associate professor of nursing education in the nursing care of children at the University of Chicago. She has written a unique book. It deals comprehensively with human relationships of significance in a branch of nursing: pediatric care. The concepts from which the author draws her conclusions are taken from Freudian psychoanalytic theory. The approach is by way of the successive stages of the development of normal personality, with pertinent physiological material included.

The book is written interestingly, with didactic and case material interspersed. Technical content is documented, technical terminology explained. Of the nine parts into which the book is divided, sections

two to nine cover the developmental stages from the prenatal period through adolescence. Each part is further subdivided under headings which indicate developmental factors of outstanding importance to the growth and development of the child. "Questions to Guide Observation" and reference lists are appended to the major sections, and there is a comprehensive index to the book as a whole.

The first section, "The Nurse's Role in Preventive Mental Health Programs of the Future," carries a title broader in scope than its contents justify, since it is limited to the mental health role of the nurse working with children. Many nurse educators would disagree, too, with the author's opinion that a prolonged period of pre-clinical education should precede the assignment of students to the care of patients. In a number of progressive programs of nursing education, students are learning early in their training to establish therapeutic relationships with patients during the course of carefully guided, actual experiences with patients.

Another possible limitation of this book is that it emphasizes one-to-one relationships to the point of neglecting the effects of group interaction in the home, school, and hospital. And although cultural factors in development are given some recognition, the child with whom the author is concerned is a member of a small, middle-class family of Anglo-American background.

Essentially, the book analyzes the emotional needs of children and their parents, and offers suggestions as to how the nurse may best meet these needs. Key statements which indicate the needs are italicized throughout the text. The numerous suggestions for the nurse's practice would, if put into effect, revolutionize and humanize the care of sick children. Their care would be planned and carried out so as to further their development as persons, rather than to serve the needs and interests of the adults who are responsible for them in hospital, home, and school.

The needs of the adults are fully recognized, however, and considered with understanding. The rich variety of ideas which this book has to offer will be of value to parents and to students in medicine, social work, and teaching, as well as in nursing. They will serve as a guide not only toward intellectual understanding of children, but also toward the achievement of increased satisfaction in working, playing, and living with children.

KATHLEEN BLACK

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New York City*

THE PSYCHOANALYTIC STUDY OF THE CHILD. Edited by Ruth S. Eissler and others. Vol. IX. New York, International Universities Press, 1954. 369 p.

Those of us who heard Anna Freud's lecture at the New York Academy of Medicine have to clarify the title, for in "Psychoanalysis and Education" *education* was interpreted in its broadest sense as a child's early training. This antedates, of course, the so-called formal education in the three R's, and as a result a re-definition of the title was in order. In actuality, Anna Freud's lecture was a review of the contemporary summation of Freudian psychology. The striking notes were centered around the element of self-control, that is, of the mature superego as an ally of character rather than the superego as a tyrannical source of frustration. To the reviewer the fact that frustration is an unavoidable part of life, and that maturation of the ego is dependent upon its ability to cope with this inevitable element and turn it into ego strength, highlighted the discussion. This thesis was broadly examined by many of our able therapists, and many old concepts were reviewed in the light of advancing knowledge. The panel was an extensive one, and I am sure that those who have followed the literature closely met old friends.

Among the panel members, Lewin and Greenacre especially had novel contributions to the "Problem of Infantile Neurosis." We were impressed with Greenacre's concept of two dynamic levels functioning at the same time, sometimes concomitantly and sometimes antipathetically. This appeared to correlate with the id level of activity and the later ego-superego contributions. Biologically it fits in with the concept of action on an automatic level and that on a higher evolutionary level of complex and more voluntarily controlled practices and procedures. These two opening chapters in themselves would be a noteworthy monograph.

There were many interesting papers by Jacobson, Kramer, Mittelman, Peller, Stevenson, Fraiberg, Bonnard, Sperling, Hellman, and the Planks under the caption of "Problems of Normal and Pathological Development." Bela Mittelman's evaluation of motility in the human being has expanded a field which up to the present has been touched upon lightly. His emphasis upon its significance is certainly a valuable contribution. Sperling is most helpful to our efforts to understand early normal maturation and incipient pathology in his article called "An Imaginary Companion." The complexity of intellectual inhibitions is illustrated by Hellman's chapter, and the paucity of our knowledge of the emotional components in arith-

metrical learning is brought home to us by the Planks in their paper entitled "Arithmetical Learning."

Buxbaum's evaluation of technique is a critical and workmanlike review of our current handling of the family and our patients with the varied methods of approach. She particularly evaluates therapy differences between the pre-oedipal and post-oedipal pathology. The symposium is concluded by some observations on therapy in a therapeutic center by Alpert and the challenge of differential diagnosis between the borderline and the psychotic child by Ekstein and Wallerstein.

In this volume we have another valuable addition to the ever-changing growth of therapy and investigation in the study of the normal and the deviant child.

EDWARD LISS, M.D.

New York City

LAUGH AND CRY: YOUR EMOTIONS AND HOW THEY WORK. By Jerrold Beim. Illustrated by Ray Campbell. New York, Morrow Junior Books, 1955. 47 p.

When this publication was considered for review it was believed that it would be interesting to have it appraised by a representative of the audience for whom it was intended. I therefore had my ten-year-old son read it and write the review that follows.

As a ten-year-old, he expressed serious dissatisfaction with the size of the publication because he stated that a boy his age was able to read bigger books. Apparently he felt that its small size seemed to have some implication about the limited reading ability or span of attention of a ten-year-old. Only after I pointed out that just a limited number of pages were required for the book, since it was a specialized one, would he agree to read it.

This publication appears to be an interesting educational device to the mental health educator. It is valuable for both parents and children to use in recognizing the nature of emotions and the part they play in the adjustment of people. The contents are sound and provide factual information about the development of emotions and their physiological effects. The book does not set out to alter behavior nor to make people better able to handle their emotional displays. For children who are curious about why and how things take place, this publication will give accurate information about typical emotional stimuli and reactions.

It can be recommended for wide use. Its contents are such that they will not add to the concern of people who tend to be anxious

about their children's behavior. The book does not stress any specific child-care practices, nor does it set up a chart of developmental standards by which the emotional growth of children can be judged.

How the book was evaluated by one young reader is printed below.

EDWARD LINZER

New York City

This book is very good in telling how you need emotions.

The pictures are wonderfully illustrated and show just what the book is talking about. The way they use Dan, Bob, and Kathy, the children, to show the emotions is good. The one thing I thought could have been better was to have the book illustrated in color to show things they talk about like tense muscles and enlarged pupils of the eye during a emotion of anger. Besides that the book is very good and I think children 7 to 12 years of age would enjoy it.

The book helped me understand how my emotions work. I enjoyed reading this book.

STEPHEN LINZER

FATHER RELATIONS OF WAR-BORN CHILDREN. By Lois Meek Stolz and others. Stanford, Calif., Stanford University Press, 1954. 365 p.

This is an investigation "to understand the role of the father in the development of children." The work was done over a period of three years, 1949-1952, and was conducted in the department of psychology at Stanford University under a grant from the National Institute of Mental Health of the United States Public Health Service. A group of 19 families of war-separated fathers from their first-born children was studied. A second group of 19 families of non-separated fathers was used as a control. The families in the control group were comparable in age, socio-economic status, and background to those of the father-separated group.

The object of this study was to determine the effect on the child of its separation from the father and its subsequent responses to the returning father, the mother, the younger sibling, and to those about him; at the same time, to notice the reactions of the war-separated father to the resumption of his marital life and his new rôle of father. In addition, the difference in the emotional development of the first-born as compared to that of the second child was investigated. The findings were obtained through father interviews, mother interviews, and observation of the children in groups and in projective play situations.

The findings and material that were obtained through the several

studies of all the individuals concerned are compiled in a fairly scientific manner and they present evidence that is objective and irrefutable. There are a number of checks on the facts obtained. For example, the communications of the mothers were readily checked against the stories told by the fathers and the validity of the reports of both parents were finally tested by the reaction patterns and behavior of the child. The great value of this investigation is that it presents most illuminating data. Moreover, there is no attempt to draw abstractions or theoretical formulations from the studies. In a plain, matter-of-fact, substantial manner this monograph makes a contribution of vital evidence with regard to the origin of such difficulties as emanate soon after birth from the family set-up and are directly related to the absence of the father, his subsequent return, and the interplay of his character with that of the child.

This research problem started with the hypotheses that "the father would have difficulties in adjusting to his first-born child after the war and his consequent attitude and behavior toward the child would affect adversely the development of the child." The father was separated from the mother during her pregnancy and reunited when the child was about a year old. The fathers "were all students or faculty members of Stanford University" at the time of the study. The 19 war-separated families had 35 children, 19 first-born and 16 second children born after the father's return to the family. The children were of average or above average intelligence. There were 12 boys and seven girls among the first-born, and eight boys and eight girls among the second-born. The non-separated families were picked to match in almost the same number of offspring.

The war-separated fathers experienced these difficulties:

1. They reject their first-born children and "reject particularly traits about which in themselves they are ambivalent." The father shows his rejection by annoyance and being distant.
2. He has a higher self-rejection score than the non-separated father.
3. He perceives himself as predominantly passive.

The findings in the first-born children are fairly clear-cut. They show the following which were not present in the first-born of the non-separated families:

1. Manifest anxieties and fears.
2. Difficult relations with other children and siblings.
3. Inability to be free with adults.
4. An inhibition of aggressive drives.
5. Detachment from their fathers.

6. Eating and elimination difficulties.
7. Increased whining and thumb-sucking.
8. Attachment to the mothers.
9. Prominence of character anomalies, such as submissiveness, defiance, unfriendliness, and lack of control of their emotions.

The interpretation of the observed phenomena tends to stress the war-separated father's role as the primary factor in the first-born's adjustment. This theme is clearly outlined on page 323 in this statement: "Under normal conditions a man usually undertakes the rôles of breadwinner, husband, and father sequentially, feeling some sense of adequacy in one before entering into the next. But for these men the tasks were telescoped in time, with consequent increase in strain. These men were in an anomalous position. They were husbands, but unsure of their relations with their wives and novices in the rôle. They were fathers, but of unknown children whom they had seen only in pictures; they lacked any warm interpersonal relations with these children and were vague and uncertain of the rôle of father. Finally, they were heads of families, without jobs, without training, and with only the faintest conceptions of what they wanted to do or how to go about making decisions."

The father, therefore, found himself unable to quickly undertake all these new responsibilities. His insecurity and inexperience hurriedly produced makeshift authoritative behavior in the form of over-disciplinary attitudes and other, both overt and covert, hostile patterns. The authors say: "... we are inclined to believe that the father-child relation has interfered in the child's normal development. The basic sense of trust which he obtained from his mother in the first year has been upset by his relations with his father. The difficulties of many of these children in establishing elimination control and the father's severe punishment by hard spanking have perhaps built shame and doubt rather than a sense of autonomy in the children. These conflicts may be related to the repressed hostility in these children. Finally, the father's authoritarian control of the child's activities has probably tended to build guilt about the child's own physical exuberance rather than to increase his sense of initiative."

The conclusions and the material elicited by the investigators of this report attempt to show that the child's difficulties arose almost immediately upon the arrival of the father on the scene. They stress the father's difficulty of adjustment and emphasize that he had to assume numerous rôles all at once and therefore was unable to cope adequately with his responsibilities of being a father. The impression is given that all these factors in the father's adjustment reacted upon the child and that these seemingly were the main operative forces to

produce the symptomatology and difficulties within the children. There is no doubt that the father's adjustment with the child is important. It is clear that the children did manifest the above mentioned difficulties and disturbances. All these findings, in and of themselves, are most valuable. The authors have substantiated the fact that the child-father relationship is most vital in character-building.

There has been a notable absence, however, of a delineation of the rôle of the mothers in the development of these first-born, war-separated children. One would get the feeling that the mothers played the usual rôle, that they in themselves were effective, that the whole malfeasance of the child-rearing came about with the arrival of the fathers upon the scene and that very little had transpired prior to that. With regard to the mothers' behavior, the authors mention the following: "The mothers tend to evidence more worry than the fathers about every area of behavior except eating and relations with other children. In discussing eating behavior, elimination behavior, and relations with other children, the wives show much greater insight into their first-borns' behavior than their husbands do. Both war-separated parents agree that the mother feels closer to the first-born child. They both feel that the first-born feels closer to his mother than to his father. Both parents report that the father's discipline of his first-born when he returned from war was severe, although the wife tends to minimize the severity of this discipline, perhaps out of loyalty to her spouse."

Stolz also says about the rearing of the children, "There were no significant differences in the methods of training used by the mothers in relation to organic needs although more war-separated children were breast-fed and elimination training was begun earlier with them. There was a tendency also for war-separated children to have more contacts with close relatives and fewer with children than the non-separated group. The development of the children in the two groups shows marked differences. In the areas of organic needs (eating, elimination, and sleeping) which are the foci of socialization during the pre-school years, the war-separated children have more serious problems. They also are less independent in eating and dressing. The war-separated children manifest more fears of a serious nature and have more overt expressions of tensions. According to the mothers' reports the war-separated children have poorer relations with other children than the non-separated children." On page 180, the authors conclude chapter 7 by saying, "In general, the findings confirm our belief that separations necessitated by war created an unusually close bond between the mothers left behind and their children born during the separation, but also induced difficulties between the fathers and the children after the latter returned from war, which difficulties

enhanced the closeness of the mother-child bond and kept the father relatively distant from his first-born child."

These observations about the mothers are rather sparse, with little attempt to glean the mothers' subjective reactions to their husbands' absence, taking the responsibility of being both mother and father to the child, the taxations put upon them, the insecurity they experienced, the envy of the non-separated mothers, the general feeling of "being alone," and the instinctual and affective frustrations. It is these very subjective reactions of the parent that play, by far, the most important rôle in the character-building and the emotional security of the child.

Yet the statements of chapter 7 show that the child is most significantly affected by the mother. The stronger bond to the mother and to relatives and elimination difficulties point to an insecurity of both the child and the mother. This predominant feature, *i.e.*, mother-child relationship, however, is not stressed as the nuclear one in the whole family pattern. As a matter of fact, the authors devote two-hour interviews to the mother and five-hour interviews to the father, apparently because of their conviction that the father-child relationship is the crucial one.

It is true that a great many of the inadequacies of the child appeared upon the arrival of the father. His entry into the family constellation is an exciting factor in increasing the difficulties of the child. In this reviewer's opinion, it is not the primary cause of the child's difficulties. The latter, if full investigation of the mother-child relationship were made, could be shown to result from subjective anxieties within the mother who had to cope alone with the whole parental support of the child which is regularly shared by both parents. That this must necessarily be the truth is borne out by psychoanalytic clinical studies of patients brought up as children by widowed or divorced mothers.

This study is on father relations of war-born children. Perhaps the authors felt it unnecessary to bring out in detail the mother-child relations. The subject, however, also indicates that the authors may have looked only in one direction and attempted to produce evidence to corroborate their original hypotheses. This may, in large part, be influenced by the rather dramatic course of events depicting the father's heroic sacrifices, his homecoming, and precipitous adjustment to the family scene that catch the eye and our sympathetic imagination. Another item of importance is that this study was undertaken after the father's return, so that much of the emphasis of the consequent child-parent relationship must be focused on the post-father rather than the anti-father period.

This book attempts to present its material in an objective, scientific

manner. There appears to be an obvious desire to disclose only fairly transparent, factual material, so that one might draw the conclusion that these revelations were not concocted theoretically. The authors, however, seem to overdo this and play up this style to a point where the report becomes at times rather tedious. There is repetitiousness and a tendency to emphasize innocuous details such as a minute description of the dictating machine used in the recording of the interviews with the parents.

This book, despite the above criticisms, has great merit and has disclosed salient findings pointing to a disruption in the make-up of the first-born child in father-separated families. Although the authors have not pointed out the significance of the mother relationship to this same father-separated child, the disclosures of the greater bond between the mother and first-born separated child and the elimination and eating difficulties of these children point to the fact that the mother probably did play the most prominent rôle in influencing the deviation of behavior, character, and symptoms in these children. The disclosures of this study add another piece of evidence to the "environmental factors" as most significant determinants in the character and emotional difficulties of human beings. The families of war-separated fathers show that the ravages of war leave their most tragic imprint on helpless victims—children born to the warriors who couldn't be there "to save them."

MORRIS D. RIEMER

Brooklyn, N. Y.

THE ORIGINS OF PSYCHO-ANALYSIS: Letters to Wilhelm Fliess, Drafts and Notes: 1887-1902, by Sigmund Freud. Edited by Marie Bonaparte, Anna Freud, and Ernst Kris. Authorized translation by Eric Mosbacher and James Strachey. New York, Basic Books, 1954. 486 p.

This fascinating volume contains 168 of Freud's 284 letters to his amazing medical colleague, the mystical Berlin otolaryngologist, Wilhelm Fliess. The selection by the three editors—Marie Bonaparte, Anna Freud, and Ernst Kris—"was made on the principle of making public everything relating to the writer's scientific work and scientific interests and everything bearing on the social and political conditions in which psychoanalysis originated; and of omitting or abbreviating everything publication of which would be inconsistent with professional or personal confidence."

The text of the letters is annotated with valuable editorial comments. The excellent introduction was written by Ernst Kris. The

final 90 pages of the volume are devoted to the reproduction of a previously unpublished manuscript to which Freud had given no title. It was written in 1895 and is the author's bold and at times quite fantastic attempt to formulate physiological theories to explain all types of nervous system activity.

This reviewer knows of no comparable revelation of the intellectual growth of an individual during a decade and a half (1887 to 1902). There is also revealed in this series of letters to Fliess the enormous fecundity of Freud's genius and his unique dependence on inspiration as a method of work. Doubtless many great creative artists have been aware of premonitory signs of labor before giving birth to some great production, but few scientists have experienced this and few of them have relied so heavily on intuition.

The letters throw a good deal of light on the unique association of Freud and Fliess. During the years of the correspondence, before Freud was surrounded by disciples, he was a scientific isolate. In one of the letters he refers to Fliess as his "indulgent audience" and adds "without such a thing I cannot work." As Kris observed, Freud's "overrating of Fliess's personality and scientific importance corresponded to an inner need of his own." Apparently, Fliess was extremely well versed in the then current biological and physiological knowledge. When Freud abandoned his quest of a physiological basis for all emotional and intellectual activity for a philosophical one, the dependence on his colleague was markedly diminished.

Freud's efforts to fit his clinical findings into Fliess's mystical numerology and his bizarre theory of the nasal sexual reflex presents a fascinating demonstration of the difficulty of even a great mind in achieving scientific objectivity. The letters also give evidence of Freud's own reckless formulations of theories. Happily, they also show the readiness with which he could abandon many of his bastard brain-children. From these letters one cannot escape the belief that Freud would himself have been disdainful of the attitude of sacredness with which certain of his slavish followers now view all his metapsychological revelations.

All in all, one must express his admiration and gratitude to the editors for making generally available this extraordinary source material. It is unfortunate that Fliess's replies to Freud's letters were not preserved, so that one could better understand this still somewhat enigmatic figure and measure the extent that his criticisms modified Freud's theories. However, if one of their series of letters was to be preserved, it is indeed fortunate that it was Sigmund Freud's.

Baltimore, Md.

MANFRED S. GUTTMACHER

TREATMENT OF THE DELINQUENT ADOLESCENT. By Harris B. Peck and Virginia Bellsmith. New York, Family Service Association of America, 1954. 147 p.

In *Treatment of the Delinquent Adolescent*, the authors draw on many years of experience to describe some of the problems and offer tentative solutions in this very difficult field. It is a contribution that should be of value primarily to workers in the field of juvenile delinquency who are already well-grounded in basic psychiatric concepts. It is written in clear and concise language that makes for easy reading. Throughout the book, clinical material is presented to illustrate pertinent points. Portions of interviews taken from recordings are frequently quoted and serve to give the reader a feeling for the author's approach to delinquents.

The theoretical considerations regarding the etiology of delinquent behavior are discussed in the first chapter of the book. The rôle of early deprivation in producing hostile behavior is especially stressed. Beyond that the authors do little more than mention a few highlights. However, they do refer the interested reader to several other sources of material through footnotes and a brief, but excellent, bibliography at the end of the book.

The most impressive aspect of the book to me was the manner in which the authors displayed their working knowledge of the problems that confront a clinic dealing with juvenile delinquents. For example, in discussing planning for institutional care, they point out how this represents the final act of parental punishment and rejection. They emphasize that even the most excellent placement leads to an exacerbation of symptoms and that during the planning period parental discord is intensified. In order to justify placement, the parents often almost deliberately provoke the child to further delinquency and force him to carry the burden of their displaced guilt. The supportive value of the clinic worker's relationship to the child is stressed and many realistic factors of placement cited. In discussing problems of this sort, the authors continually strive, and quite successfully, to sharpen the focus not only in terms of the child's dynamics but also in terms of the viewpoint of the parents, society, and other social agencies.

Over half the book deals with the use of groups. These are not considered as a time-saving device but rather as attempts to reach individuals not accessible through individual treatment. The authors are obviously impressed by the value of group techniques and have applied them to all aspects of their work even including the intake process. They do not present any new theoretical concepts regarding group therapy but rather give a first-hand account of their experi-

ences in applying these methods to juvenile delinquents. They present a large amount of clinical material here that is quite interesting, but at times repetitious. The material was sufficiently convincing to lead me to share in the authors' enthusiasm for group therapy with adolescents and their parents.

This book is not intended as an effort to exhaustively cover the problem of treatment of the delinquent. It is an authoritative account of the authors' application of psychiatric principles in their work with adolescents. I would recommend it highly to any person with psychiatric training who anticipates being engaged in treating delinquent adolescents or is now so engaged.

ROBERT W. GIBSON

Rockville, Maryland

NOTES AND COMMENTS

AID FOR THE MENTALLY RETARDED

Congress took an important step last year in recognizing the needs of mentally retarded children by voting the National Institute of Neurological Diseases and Blindness an additional \$500,000 to augment its study of mental retardation. The National Institute of Mental Health received an additional \$250,000 to expand its research and training programs on behalf of mentally retarded children.

Congressman John E. Fogarty of Rhode Island, chairman of the House subcommittee on appropriations for the Department of Health, Education, and Welfare, spearheaded the move for additional funds for a broadened program on behalf of the mentally retarded.

Though the Neurological Institute has not made any study of mentally retarded children as patients, some of its basic research bears on the problem. A good part of the new funds will go for a study of the causes of brain damage and methods of prevention.

NIMH is using its additional funds for studies on such topics as the relationship of pregnancy and birth difficulties to mental retardation, diagnostic and case-finding techniques, and prenatal factors in mental retardation; for grants to professional personnel working with the mentally retarded; and for research on methods of preventing and handling mental retardation.

Other federal agencies concerned with problems of the mentally retarded are the Children's Bureau, which works with health and welfare agencies in developing community services for the retarded, and the Office of Education, which collects and disseminates information on educational needs and services for all the various types of exceptional children and provides consultative service on the preparation of teachers of exceptional children.

NEW INSTITUTION NAMED FOR PROFESSOR JOHNSTONE

The former Bordentown (N. J.) Manual Training School, slated to start operation in the spring as a training and research facility in mental deficiency, will bear the name of the late Prof. Edward R. Johnstone. Internationally known for his work in the field of mental deficiency, Professor Johnstone was assistant superintendent, superintendent and executive director of the Vineland Training School from 1898 to 1944.

The new institution will provide six main types of training for the mentally deficient:

1. Work experience in a simulated factory.
2. Cooperative education in the community's industries and farms.
3. Prevocational and vocational education.
4. Academic education for practical use in work and leisure-time activities.
5. Family life education designed to eliminate deficient social characteristics.
6. Special training in self-help and self-care for middle-grade retardates aimed at preparing them for return to their families; for children having unusual potentials; and for specific groups such as deaf and blind deficient.

DEDICATE MENTAL HEALTH PAVILION

Short-term treatment of adult psychiatric patients, including psychotics, will be available in the new seven-floor \$2,500,000 Jacob L. Reiss Mental Health Pavilion of St. Vincent's Hospital, New York City, dedicated January 28. The clinic can care for 97 in-patients, with a maximum stay of three months, and an unspecified number of out-patients.

Mayor Robert A. Wagner, Jr., pointed out at the dedicatory ceremonies that "increasingly we are all becoming aware that the ills of the body and those of the mind cannot be separated. We are coming to realize that the practice of modern medicine is not complete unless full recognition is given to the fact that so-called physical ills have their effects upon the patient's emotions and behavior, and that emotional disturbances may in turn bring about or be reflected in physical disturbances."

Lt. Gov. George B. DeLuca, representing Governor Averell Harri-man, noted that "mental illness in its most serious form touches one family in every four." He said the state mental hospitals now have a total of 116,000 patients and that one-third of the state's total operating budget is required for their care and treatment.

MORE FAMILIES ASKING HELP DESPITE PROSPERITY

In a seeming paradox, American families are experiencing greater prosperity and, at the same time, seeking the help of family service agencies in greater numbers than ever before, according to Hugh R. Jones, president of the Family Service Association of America.

During 1955, when the nation found assurance in a record 540-billion-dollar national output, the 265 Family Service agencies affiliated with the FSAA counted approximately 1,000,000 persons in the families requesting and receiving counseling and assistance with personal problems. Explaining that higher income does not necessarily mean fewer family troubles, Mr. Jones said:

1. Although never before have so many American families realized such a large amount of their material wants, this is never the full answer to the problems of human relations. In fact, said Mr. Jones, "industrial expansion itself may contribute new social complexities, such as the increased mobility of families."

2. More people may be availing themselves of the help offered by Family Service agencies and other professional services, simply because these are becoming better known, understood, and accepted.

3. All of the helping professions, including the Family Service agencies, are feeling the impact of another tremendous factor, simple population growth. Mr. Jones emphasized that "in 20 years our population has swelled by 36 millions. Now a country of 166 million people, there will be 185 or 190 million Americans in 10 more years. We are having ever more children and teen-agers, ever more people over 65. There are millions more people within close access to our existing family agencies; millions of others who have been on the march to suburbia and to new communities where insistent demands for new agencies are arising."

This "growth" factor alone is a major reason why "in a very high proportion of our member agencies today, services given are close to capacity of staff," Mr. Jones said. "Nearly a quarter have had to establish waiting lists for appointments."

At the same time, lower enrollments in schools of social work in recent years have made the situation even more urgent.

"Inability to obtain staff is threatening the very existence of some of our smaller agencies," the FSAA president declared. "Much as we shall need more engineers and teachers in the next decade, we shall also need more social workers—some 50,000 of them. It is not too much to say that the welfare of the country requires that social work shall not be outdistanced by other professions in attracting young people."

CLINIC FEE SYSTEMS VARY WIDELY, STUDY SHOWS

Fees in psychiatric clinics and family agencies vary so widely that families with similar incomes may receive services free or be charged totally different amounts for similar types of service.

This was revealed recently in two surveys prepared by the research department of the Welfare and Health Council of New York City, which examined fee-charging in voluntary psychiatric out-patient clinics, and in family casework and homemaker services, as the first two in a series of studies which will eventually cover all fields of social service in the city.

"The studies indicate," according to J. Donald Kingsley, executive director, "that a family of four with a \$6,000 income may be given service free or be charged from \$1 to \$6 for an individual counseling interview, or from less than \$2 to more than \$8 per visit for individual psychotherapy. This is merely one example."

Mr. Kingsley pointed out that whereas voluntary welfare and health agencies used to serve indigent groups primarily, they now serve a broad section of the community. With growing recognition that people above some minimum income level could and should pay something for such services, he added, the practice of charging fees has spread.

"With the increased demand for social and health services not being matched by increased public and philanthropic funds," Mr. Kingsley said, "fees should not be overlooked as a source of income for the agencies. On the other hand, it would obviously be undesirable for agencies to increase fees just to meet their own financial pressures without regard to the groups served."

He called for a review of existing fee-charging policies, and development of a community-wide standard to eliminate inequities and reduce the multiplicity of fees paid.

Council findings showed that about three out of four of the 51 representative psychiatric clinics surveyed charge fees of one type or another for some or all their services. Most also provide free services to patients unable to pay. Current fee scales, however, bear no consistent relationship to ability to pay as measured by a family budget standard. Families whose income is below the level needed for a modest but adequate standard of living may have to pay for service. On the other hand, families who may actually be able to pay all or nearly all the cost of services receive them on a subsidized basis.

Fees provide a relatively small share of operating income, ranging from less than four percent to about 13 percent for family agencies and from less than five percent to 25 percent in psychiatric clinics. A few of the latter, which are operated independently, obtain a major share of their operating budget from fees.

Copies of the two studies are available for 50¢ each from the Publications Department, Welfare and Health Council, 44 East 23rd Street, New York 10, N. Y.

BIOMETRICS UNIT ADDED

A biometrics unit—a research group which will bring biometric methods to bear on the problems of psychiatry—was added to the New York State Department of Mental Hygiene on February 1 by Dr. Paul H. Hoch, commissioner. The unit is located at the New York State Psychiatric Institute in New York City.

The new section was set up under the department's new nine-point program, Dr. Hoch said, to provide proper scientific statistical evaluation of the department's current and projected research. Dr. Joseph Zubin, principal research scientist in biometrics, is in charge.

Biometrics is the mathematical analysis of biological data, Dr. Hoch explained. In the study of mental disorders, it provides techniques and methods for assaying the physical, physiological, psychological and social characteristics of individuals and groups of mental patients. It is particularly helpful in screening, diagnosis and prognosis, Dr. Hoch added.

The work is carried on partly in the offices of the Institute, but centers in the state hospitals, Commissioner Hoch said. The scientists work directly with patients and their records.

In addition to his post at the Psychiatric Institute, Dr. Zubin is an adjunct professor at Columbia University and a consultant to the Veterans Administration, National Institute of Mental Health. He is a graduate of Johns Hopkins University and received his doctorate from Columbia University in 1932.

He is a member of the American Psychological Association, American Association on Mental Deficiency, American Statistical Association, and American Psychopathological Association. He is a diplomate of the American Board of Examiners in Psychology.

Author of numerous articles and papers, Dr. Zubin is associate editor of the *Journal of Personality* and of *Psychological Monographs*. He also served as associate editor of the *Journal of Applied Psychology* from 1942 to 1948 and the *Journal of Experimental Psychology* from 1947 to 1950.

HEADS EUGENICS SOCIETY

Dr. Harry L. Shapiro, chairman of the Department of Anthropology at the American Museum of Natural History, has been elected president of the American Eugenics Society. He is also professor of anthropology at Columbia University and research associate in anthropology at the Bishop Museum in Honolulu. A past president of the American Anthropological Association and the American Ethnological Association, he is a member of the National Academy of Sciences. In addition to contributions to many scientific journals, Dr. Shapiro has published two books, *The Heritage of the Bounty* and *Migration and Environment*.

The American Eugenics Society is an educational membership organization concerned with the genetic changes in human populations. Dr. Alan F. Guttmacher, director of obstetrics and gynecology at Mount Sinai Hospital, New York City, has been elected vice-president. Chauncey Belknap, New York City lawyer, has been reelected treasurer and Frederick Osborn, demographer, has been reelected secretary.

VA HOSPITALS INITIATE NEW PROGRAM

Faced with ever-growing numbers of aging long-term patients, 13 Veterans Administration hospitals in the east have taken the lead in activating an entirely new concept in federal medical treatment. Known as the intermediate program, it will have the primary aim of providing active treatment rather than custodial care for long-term patients whose discharge is not yet advisable despite extended acute treatment.

The program stems from the increasing age level and attendant chronic illness of America's 22,000,000 veterans. Today the average age of these veterans is 38 and only 600,000 have reached the age of 65. By 1960 it is estimated that the average age will be 41 and that more than 1,780,000 will be over 65.

To combat this problem, VA has extended the intermediate program for all-out care to at least 30 hospitals in the United States. Selected for intensified test studies are VA hospitals at East Orange, N. J.; Albany, Bath, and Buffalo, N. Y.; West Haven and Providence in New England; Beckley and Martinsburg, W. Va.; Erie, Pittsburgh, and Wilkes-Barre, Pa.; Fort Howard, Md.; and Keeoughtan, Va.

Medical specialists of these hospitals met in two groups recently, at Albany and East Orange, to consider the problem as it affects both mental and medical long-term patients. Application of the program to eastern hospitals where waiting lists in metropolitan areas have created complications received attention.

Acuteness of the problem was emphasized by Dr. Irvin J. Cohen, VA's director of hospitals and clinics, who pointed out that more than 9,000 VA patients have been hospitalized for more than 20 years; half of the 55,000 VA mental patients have been in hospitals at least five years; and more than 4,000 of 18,000 aging veterans in VA domiciliaries are now bed-ridden and no longer suited for domiciliary care.

Dr. Cohen emphasized that the intermediate program, which is becoming an important phase of VA's medical activities, will deal with both mental and non-mental cases and will have two primary aims: It will work for ultimate discharge of the patient, but during the prolonged period of hospitalization it will seek ways of improving his care so that he will develop maximum ability to help himself.

The conference at Albany dealt mainly with the long-term psychiatric patient for whom a new type of "total push" program in VA hospitals is opening the doors of closed wards. Successfully tested at the VA general medical and surgical hospital in Albany, the program represents one of the first comprehensive attempts to recondition selected long-term psychiatric patients from closed wards in neuro-

psychiatric hospitals to open wards in general medical and surgical hospitals.

The patients generally selected for the treatment have both mental and physical disabilities and have shown little change in their mental condition after many years of treatment in neuropsychiatric (NP) hospitals.

The objective in transferring them to general medical and surgical (GM&S) hospitals is to provide more intensive treatment and rehabilitation for their physical disabilities and, at the same time, to apply "total push" measures in reconditioning them for greater freedom and independence in the hospital and community.

VA explained this frees beds in NP hospitals for those on the waiting list who need extensive psychiatric treatment, and also benefits the long-term mental patients with physical disabilities because of their transfer to a different type hospital where the major patient load is non-mental and where treatment primarily is oriented toward physical disabilities.

While the primary goal of the new "total push" program is to make long-term mental patients more suitable for GM&S hospitalization and thereby eliminate the need for lock-ward security, the Albany studies indicate some patients actually can be improved to the point of discharge to their families.

Albany reported the following results in three years of working with approximately 350 chronic schizophrenics, some of whom had been hospitalized in closed wards of NP hospitals for as long as 35 years:

1. All patients live in open wards, in daily contact with non-mental patients.
2. Sixty have progressed to the point where they are working regularly at jobs in the hospital.
3. Fourteen already have made trial visits home and 10 more are slated for similar pre-discharge privileges—a remarkable accomplishment in itself in view of their long hospitalization, VA said.

The Albany approach resulted from an emergency transfer in 1952 of long-term patients from crowded NP hospitals in the east to GM&S hospitals in less crowded areas. The transfer quickly enabled VA to care for large numbers of additional mental cases in vacated NP hospital beds and thereby relieve some of the pressure on its waiting list, but it also created many new problems at the GM&S hospital in Albany.

Despite these problems, Dr. Ian C. Funk, chief of psychiatry at Albany, and his chief clinical psychologist, Leo Shatin, decided from the beginning to prove both the "safety" and the potentialities for improvement of these older chronic patients.

They kept security measures at a minimum. Wards were opened

where possible, and the patients used regular dining room facilities. Recreational areas and activities in the 11-floor building were made available to the mental patients.

Employees throughout the hospital came in frequent contact with almost all of the transferred mental patients. The patients also were permitted day-to-day contact with younger and non-mental patients.

Dr. Funk and his staff next evolved a program of group psychotherapy to supplement and expand the open ward type of treatment. In this program, Dr. Funk had the assistance of Dr. Leonard Rockmore, staff psychiatrist, and Dr. Earl X. Freed, staff psychologist.

Dr. Funk explained that "total push" through group therapies is not a new concept. He said such programs in VA mental hospitals have shown considerable success in inducing mental patients to re-socialize and readjust themselves to others through the exploitation of mutual interests.

In Albany, however, the "total push" program was designed primarily to recondition long-term mental patients to open wards in a GM&S hospital and thereby permit freedom of the hospital and maximum rehabilitation.

VA said the success of the "total push" program at Albany is one of the bases for the current expansion to other GM&S hospitals capable of developing the program.

NEW JERSEY STUDIES ATTITUDES TOWARD MENTAL ILLNESS

Judging from results of a survey sponsored by New Jersey's Department of Institutions and Agencies, the public is ready and willing to back a well organized, all-out campaign to fight mental illness.

Sixty-six percent of 1,209 persons interviewed said they would be willing to discuss mental illness of a member of their family with friends and acquaintances. Half said they felt mental illness was nothing to be ashamed of and should be discussed as freely as any other illness.

According to Dr. Robert C. Myers, chief of community mental health services for New Jersey, this is encouraging to those who feared shame would prevent a large public campaign on behalf of the mentally ill from getting off the ground.

Only 15 percent of the 1,209 said they considered mental illness an inherited disorder. Six out of 10 said they personally knew someone who had been hospitalized for mental illness, and a third of these said it had been a relative. Sixty-three percent believed there are not enough doctors or hospitals to give proper care and treatment for the mentally ill.

Forty percent thought most persons who lose their minds eventually recover, another 16 percent thought it was a 50-50 proposition, 26 percent felt there was little or no hope of recovery, and 18 percent ventured no opinion.

Those interviewed believed most mental disorders stem from five principal sources: worry over financial difficulties, a run-down physical condition, alcoholism, overworking the brain, and, in women, the menopause. With patients of 60 and older now making up over a third of all mental hospital admissions, aging should be more widely recognized as a source of mental illness, Dr. Myers points out in *New Jersey's Welfare Reporter*.

Seventy percent of the 1,209 interviewees believed sex perversion indicates mental illness. Other signs, they said, are drug addiction, chronic alcoholism, murder, feeble-mindedness, and juvenile delinquency. "Although New Jersey has recently made a start in establishing special psychiatric facilities for research and treatment of sex perversion, drug addiction, and chronic alcoholism," Dr. Myers writes, "many state legislatures have held back in endorsing such a move for fear the voters were not advanced or liberal enough in their thinking to go along with such a non-punitive approach to these major problems of aberrant behavior."

The survey, conducted by Dr. George Gallup's Audience Research, Inc., included Jerseyites in all walks of life.

PERSONALITY DETERMINES QUALITY OF TEACHING, STUDY SHOWS

One way to tell a good teacher from a poor one is to find out whether or not she likes her pupils, according to a study of teacher personality traits by Dr. Percival M. Symonds, professor of education in the Department of Psychological Foundations and Services at Teachers College, Columbia University.

Dr. Symonds conducted the study with a grant from the Council on Research in the Social Sciences of Columbia University. He is a leading educational and clinical psychologist and a well known author in his field.

The aim of the study was to determine the characteristics of an effective teacher by analyzing pupils' reactions to their teachers. It was made on the premise that "one of the important outcomes of education is the formation of attitudes by pupils, particularly attitudes toward the school, toward learning, and toward teachers."

Dr. Symonds concluded that the three major differences in the personalities of poor and good teachers seemed to be these:

1. Superior teachers liked children; inferior ones disliked them.
2. Superior teachers were personally secure and self-assured; those

less efficient were insecure and had feelings of inferiority and inadequacy.

3. Superior teachers were well adjusted and possessed "good personality organization"; inferior ones were personally disorganized.

The study was conducted in a junior high school with 32 teachers and 453 pupils taking part in the test.

In the first part of the study, pupils were asked to rank their teachers on such questions as: Which of your teachers makes the work most interesting? Which of your teachers understands you best and likes you most?

To find how valid pupil rankings were, the principal of the school was asked to rate the teachers on such characteristics as "disciplining control" and "relationship with pupils."

Dr. Symonds found that the principal tended to agree with her pupils' reactions. For example, teachers who received favorable reactions from their pupils tended to be rated highly by the principal as far as the teachers' "relationship with pupils" was concerned.

After the teachers had been placed on a scale according to the pupils' reactions, a number of them, from the top and bottom of the scale, were observed to determine the differences between those who had been ranked high and those ranked low by their students.

The superior teachers showed their liking for boys and girls in many ways, according to the observers. They were interested in their pupils, knew their names, and knew something of their backgrounds and interests. Each pupil was respected as an individual and was given responsibility for various phases of the class work.

Inferior teachers showed their dislike for children by displaying a cold and unapproachable attitude and by complaining how stupid, lazy, and troublesome some students were. These teachers tended to expect the worst from their students, the study reported.

A teacher who is personally secure is defined by the study as one who "believes in himself and in what he stands for. The person with inner strength stands secure, has no need to be little or humble himself, has no cause to doubt his status or abilities."

In classes with superior teachers, observers noted that there was "no doubt" who was in control. The classes were orderly and well disciplined, and control was never a problem.

Some superior teachers were formal and precise, but they were always in command. Others were more casual. They could afford to show a sense of humor and to enjoy a joke.

Inferior teachers were characterized by scolding, nagging, bullying, threatening, and picking on students and by the use of sarcasm and ridicule. These methods were used largely to prevent disorder.

It was discovered that the better teacher used punishment less frequently.

The less able teachers displayed an obvious feeling of inferiority and inadequacy with their pupils and, in some cases, actual fear of pupils.

Superior teachers organized their work more effectively. Goals were more clearly defined to students and a clear-cut time-table for their accomplishment was presented to pupils.

Observers noted that the better teachers worked a little harder and liked their work better. The inferior teacher was not so devoted to her work. At the end of class, some would sigh with relief and show obvious pleasure at seeing the pupils leave. Preparing for a class was an unpleasant chore for them.

Students in the classes with inferior teachers were more disorderly and their activities did not show the straight-forward approach to clearly defined goals, the study said.

Dr. Symonds concluded that effective or ineffective teachers cannot be spotted through particular behavior. Good teachers were found among those who maintained a formal attitude in the classroom and among those who were casual. The basic determinant is in the inner personality of the teacher, however, rather than in outward behavior in class, Dr. Symonds believes.

GIFTS BUILD UP INSTITUTIONAL LIBRARIES

The Josiah Macy, Jr., Foundation recently distributed 44 volumes to each of the 376 mental hospitals and clinics listed in the 1952 Directory of Psychiatric Clinics. The books represent the Transactions of 10 multi-professional conference groups on various aspects of medical research.

Though some do not apply directly to mental problems as such, the Macy Foundation expressed the hope that "these volumes will help to counteract the tendency to isolate mental health problems from the broad field of medicine and in a small way contribute to the promotion of good mental health."

LETCHWORTH VILLAGE EXPANDS RESEARCH PROGRAM

With additional funds from the New York State Department of Mental Hygiene, the research department of Letchworth Village, Thiells, N. Y., one of the nation's oldest centers for the study of mental deficiency, has added a section on biochemistry. Fred B. Goldstein, Ph.D., who is in charge, will study abnormal metabolisms in certain types of mental deficiency.

Research at Letchworth Village was begun years ago under the sponsorship of Mrs. E. H. Harriman, mother of Governor Averell Harriman of New York.

SIGNIFICANT MEETINGS

The National Association for Music Therapy will hold its seventh annual conference October 18-20, 1956, in Topeka, Kans. Discussions will center on new and useful applications of music for therapeutic purposes.

Music Therapy 1954, latest proceedings of the NAMT, contains more than forty papers presented during the fifth annual conference in New York in 1954. Allen Press, Lawrence, Kans., will take orders at \$5.20 per copy.

With "The Challenge of Change!" as its theme, the National Conference of Social Work will hold its 83rd annual forum May 20-25 in St. Louis. In six general sessions, about 50 section meetings, and another 15 meetings on common problems, social workers and laymen will consider how social welfare meets the challenges of a changing economy, population, and world. About 125 organizations associated with the NCSW will meet in St. Louis during the week of the forum. They include the National Association for Mental Health and the National Professional Committee on the Social Aspects of Epilepsy.

The 84th annual meeting of the American Public Health Association and meetings of 40 related organizations will be held in Convention Hall, Atlantic City, N. J., November 12-16. More than 4,000 professional public health workers are expected to attend the scientific sessions and view the technical and scientific exhibits.

Explorations into the question, "Where Are We Going in Public Health?"—undertaken at the 83rd annual meeting last November—will be continued. The 13 sections of the Association—dental health, engineering and sanitation, epidemiology, food and nutrition, health officers, laboratory, maternal and child health, medical care, occupational health, public health education, public health nursing, school health, and statistics have been augmented this year by a new section on mental health. All will be responsible for programs in their specialties.

Plans are under way to direct the program content of at least one day to the interests of the young public health worker.

The American Public Health Association, with headquarters at 1790 Broadway, New York City, is the largest society of professional public health workers in the world, with more than 12,000 members. The president is Dr. Ira V. Hiscock of Yale University.

Syracuse University will sponsor a workshop in family relations July 2-20 that will demonstrate how the contemporary American

family affects the behavior of school-age boys and girls. Three specialists in child development, psychiatry and sociology will pool their experiences to provide workshoppers with insight into family relationships.

They are Dr. William F. Knoff, assistant professor of psychiatry at the State University of New York Up-State Medical Center, Dr. William P. Mangin, instructor in sociology and anthropology at Syracuse University; and Dr. Elizabeth Moore Manwell, assistant professor of family relations and child development in the college of home economics at Syracuse.

Slated for consideration in lectures and discussions are such questions as: What goals and techniques in parent education are recommended today? How can the adult and child handle anxiety and hostility wisely in school relationships? Which forces in our society work for and which against the stability of family life?

"Teachers, parents, school administrators, religious leaders and social workers will all benefit from this workshop," announced Dr. William Cruickshank, dean of summer sessions at Syracuse. For further information, write Dr. Mangin, Department of Sociology and Anthropology, Syracuse University, Syracuse 10, N. Y.

Franz J. Kallman, M.D., professor of psychiatry at Columbia University, whose research on twins has been supported in part by the Supreme Council, 33°, Scottish Rite Freemasonry, Northern Masonic Jurisdiction, through the National Association for Mental Health, is chairman of the United States committee for the First International Congress of Human Genetics in Copenhagen, Denmark, from August 1 to 6, 1956. The congress plans to cover all genetic aspects of normal and pathological character in man. Anyone interested in human genetics, especially medical genetics, is invited to participate. Provisional programs and further information are available from the Secretariat of the First International Congress of Human Genetics, The University Institute for Human Genetics, 14, Tagensvej, Copenhagen, N., Denmark.

The Second International Congress on Mental Deficiency will be held in Geneva in August or September 1958. Dr. Romaine P. Mackie is chairman for the United States and other North American committees.

A community can improve its health facilities if its people organize and work together for betterment.

Case histories of five counties proved that point at the eighth annual meeting of the National Advisory Committee on Local Health Departments in New York City, February 1. Close to 100 representatives

of national health, welfare, and civic organizations and official health agencies took part in the discussion, including Dr. George S. Stevenson, editor of *MENTAL HYGIENE*.

A 33-year story of frustration and final success in Saline County, Kansas, was reported by Dr. Henry C. Huntley of the New York Regional Office of the U. S. Public Health Service. He told how community interest in a mental health guidance center sparked the establishment of a county-wide health department.

Experience in four other counties also pinpointed the necessity for broad citizen participation, realistic facing of political facts, intensive voter education, and maintenance of public interest after original objectives have been achieved. They were Erie County, Pa.; Jackson County, Ohio; Woodford County, Ky.; and Burlington County, N. J.

Dr. Erval R. Coffey, health officer of Greenwich, Conn., listed three basic steps in obtaining health services for a community:

1. Learning the health facts about the community and getting the facts to the people.
2. Involving all groups in the community in the betterment effort.
3. Maintaining public interest after the initial victory.

TO CONDUCT COURSE ON REHABILITATION

Applications are now being accepted for the third annual practical workshop on team concepts and techniques in rehabilitation to be held at the Institute for the Crippled and Disabled, New York City, and conducted jointly with Columbia University, May 28 through June 22.

This year's course places heavier emphasis on working with clients. Enrollees will have broad opportunity to practice their skills and professions on a team basis in collaboration with the Institute's comprehensive rehabilitation staff.

The course will include seminars in rehabilitation philosophy and principles, continuous case seminars conducted by the enrollees, and participation in the presentation of certain cases to the student seminar and to the Institute's staff case conference. Lectures and discussions by guest specialists and visits to other rehabilitation facilities in the New York area will be included.

Persons in the following categories will be considered for enrollment: physiatrists, psychiatrists, and other medical specialties, psychologists, social workers, vocational counselors, placement workers, physical therapists, special educators, occupational therapists, workshop supervisors, administrators, speech therapists, and group workers.

As in previous years, enrollment will be limited to 25 so as to assure personal attention by the participating Columbia and Institute staffs to the teamwork training of each enrollee. Special attention will be

given to the role within comprehensive rehabilitation of the specialties and disciplines represented by those attending the course.

The fee for the course is \$100. This does not cover such expenses as transportation and living costs. The Institute is endeavoring to arrange for a limited number of stipends payable at the conclusion of the course to help defray travel and residence expenses for those whose residence changes in connection with the course would work a financial hardship.

Enrollees who meet the entrance requirements of Teachers College, Columbia University, may take the June workshop for three graduate credits as "Education sj 249 RW." Persons interested in applying or obtaining further information should contact Dr. Abraham Jacobs, Department of Psychological Foundations and Services, Teachers College, Columbia University, New York 27, N. Y. Applications received by May 4 will be given preferential consideration.

SCHEDULE STUDY TOURS

Donald S. Howard, educational director of the official low-cost study tours being planned in conjunction with the 8th International Conference of Social Work in Munich, Germany, August 5-10, has announced the appointment of three tour leaders.

They are Phyllis Burns, director of welfare services, Canadian Welfare Council, Ottawa; Violet M. Sieder, professor of social work, New York School of Social Work, Columbia University, New York City; and Charles Jordan, in charge of European operations for the American Joint Distribution Committee, Paris.

Delegates leaving New York by chartered plane on July 14 will have a choice of tours: one combining visits to England, France, and Holland; one to Norway, Sweden, and Denmark; and one covering Italy, Yugoslavia, and Austria.

The tours will have two purposes: to stimulate attendance at the Munich conference by facilitating low-cost travel and to enrich the experience of those participating by providing an opportunity to meet with people from all over the world.

Following the conference, delegates will have free time in which optional sightseeing trips will be available. The return trip will be made by planes from Paris to New York on August 17 and 30.

Inquiries about travel arrangements and expenses should be made as soon as possible to the official travel agency: Ambassador Travel Agency, 27 William Street, New York 5, N. Y.

Preliminary conference programs and information about housing, registration, etc., may be secured from the U. S. Committee of the ICSW, Room 300, 345 East 46th Street, New York 17, N. Y.

APPOINTMENTS

Dr. Leon L. Rackow, director of professional services at the Veterans Administration hospital in Montrose, N. Y., has been appointed manager of the 1,965-bed institution for the care of neuropsychiatric patients. He succeeds the late Dr. Richard L. Harris.

PUBLICATIONS OF INTEREST

In *State Action in Mental Health, 1955*, the Interstate Clearing House on Mental Health has summarized last year's financial, legal, and administrative developments in state mental health programs. The 66-page compilation measures to some degree the extent "to which recent conferences, studies, reports, and recommendations have resulted in legislative action." It also provides some comparison among the states of relative progress in various aspects of their mental health programs.

The major portion deals with finances and compares appropriations for current and past fiscal periods. Sidney Spector, director of the Clearing House, points out that although "the data are comparable for the two fiscal periods within a given state, they are in no way valid for interstate comparisons," varying widely in terminology and detail. The figures indicate that almost half the states "now make specific appropriations for research and training."

State budget officers, directors of legislative service agencies, and commissioners of state mental hospitals and mental health programs supplied material for the report, designed in part to assist states in further improving their mental health programs. Copies are available for \$1.50 each from the Interstate Clearing House on Mental Health, Council of State Governments, 1313 East Sixtieth Street, Chicago 37, Ill.

* * *

An historical study of the disposition of first admissions to a state mental hospital has been published by the U. S. Public Health Service as Public Health Monograph No. 32. Recounting the experience of the Warren State Hospital from 1916-50, the study demonstrates the use of life-table methods for determining probabilities of stay in the hospital. The researchers—Morton Kramer, Hyman Goldstein, Robert H. Israel, and Nelson A. Johnson—used three variables: age at time of admission, diagnosis, and time period of admission. They will report later their findings on the influence of other variables—sex, marital status, and residence (urban or rural).

In *Disposition of First Admissions to a State Mental Hospital* they report four highlights:

1. There was an increased first admission rate to Warren State Hospital from 1916 to 1950 in all age groups. It was particularly marked among patients 65 and over. The researchers question whether this reflects a true increase in the incidence of mental disorder in the geographic area served by the hospital or merely an increased use of expanding facilities?
2. The probability of release in the first year following admission for patients with functional psychoses from 1946 to 1950 was considerably greater than that for patients admitted in each of three earlier periods. Does this mean, the researchers ask, that the various therapies—electroconvulsive therapy, insulin, group psychotherapy, occupational therapy, and so on—used in increasing volume during 1946–50 have been responsible for this increase in release rates or have other factors been responsible: the kinds of risks admitted, comparability of diagnosis, condition of patients at time of release, administrative factors, and community and familial factors?
3. Patients with senile and cerebral arteriosclerotic psychoses have very slight chance of being returned to the community. Their death rates, particularly in the first few weeks and months following admission, are exceedingly high.
4. Functional psychotics as well as other categories of patients who have not been released in the first year of hospitalization experience considerably reduced probabilities of release in the second and subsequent years of hospitalization. Furthermore, patients admitted from 1946 to 1950 who have attained their second and third years of hospital life have approximately the same chances of being released in the following year as had similar groups of patients earlier.

* * *

The *Transactions of the Society of Biological Psychiatry* contain an abstract of a paper by Dr. A. Hoffer and Dr. H. Osmond on "Schizophrenia: An Autonomic Disease." The authors, both on Saskatchewan's Committee on Schizophrenia Research, have developed a working hypothesis regarding the physiological mechanism of schizophrenia which states that in a biochemically predisposed individual something produces an increase in para-sympathetic and thus in sympathetic activity. The increased production of adrenalin, they write, forces detoxification into quinone indoles, which interfere with cerebral energy production and result in clinical disorder. The paper was presented at the Society's tenth annual convention and scientific program in Chicago last June.

A new National Health Council *Directory of Member Organizations* is off the press to meet an "unprecedented need for the concise facts it offers about fifty national groups interested in health betterment," according to Philip E. Ryan, NHC executive director.

The 100-page directory is the largest ever issued by the Council. Its immediate predecessor listed 48 members and the first NHC directory, published 35 years ago, listed only 13.

Mr. Ryan explained that the "unprecedented need" for the directory stems partly from today's accelerating tempo of change in health demands and services.

"New health groups and programs are being organized at a rate we have never before known," he said. "A guide among them is increasingly necessary. In greater measure the heightened need grows out of the radical changes that are taking place in the nature of the health problems to be met, and consequently in methods of dealing with them.

"With the communicable diseases held at bay, the chronic illnesses and long-term disabilities have moved out into the center of the arena in force. Fighting these latter is far more personal than was the conquest of the earlier killers. Yet the sufferer can often do little to help himself unless the community provides facilities and services.

"The premium is therefore upon both individual and organized community action, and information and aid are essential to both. The directory describes the many services and materials which Council members offer to both persons and community groups."

The directory is available for 75¢ from the National Health Council, 1790 Broadway, New York 19, N. Y. Quantity purchasers will receive special rates.

The January issue of *Harper's Magazine* contains a 6-page article called "St. Elizabeths: Pace-setter for Mental Hospitals," by Natalie Davis Spingarn. The blurb notes that the reader, as a taxpayer, owns and supports "one of the world's best centers for treating mental illness—a pioneer for the last hundred years."

Proceedings of a workshop on "The Team Approach to the Rehabilitation of the Handicapped Homemaker," conducted last spring by the University of Connecticut, have been published. Copies are available for \$1.00 from Dean Elizabeth Eckhardt May, School of Home Economics, University of Connecticut, Storrs, Conn. The publication includes recommendations for engineers, home economists, nurses, occupational therapists, physicians, physical therapists, rehabilitation counselors, and social workers, as well as the handicapped homemaker and her family. A 30-page bibliography and film list add greatly to the value of the publication.

The Illinois Department of Public Welfare has published a study called "The Aged and Aging in Illinois: Part II—The Mentally Deficient." The study's text and tables indicate that the state institutional mentally deficient population is growing three times faster than Illinois' general population; that first admissions are generally younger than in the past; that discharges, in the main, are older; and that death occurs at an older age than in previous years.

Part I of the study—The Mentally Ill—appeared in June 1954.

Aaron L. Rutledge, leader of the counseling service and counseling training program of the Merrill-Palmer School has printed a simplified record system for counselors. As an aid to counseling and a means of collecting uniform data for research, he has developed a four-page folder for personal and family data and relationships and for the counselor's notes. Called an Individual and Marriage Counseling Inventory, the folder is available from the Merrill-Palmer School, 71 East Ferry Avenue, Detroit 2, Mich., at 20 forms for \$1.00, 50 for \$2.00.

Alert to the rapid growth of leisure-time clubs for the aging, a committee of the division of services for the aging of the Nassau County (N.Y.) Council of Social Agencies has produced a useful 16-page booklet called "Suggested Standards and Practices for Organizing and Operating Activity Programs for Older Adults." It states appropriate purposes for organizing groups for older adults; lists the steps in organization, covering such matters as membership, sponsorship, location and space, safety, promotion and public relations, schedules, transportation, finance, and record-keeping; describes adequate administrative structure; lists the personal qualifications of volunteers and club leaders, with their duties and training requirements; and suggests program ideas and sources of leaders for special projects. A final section points out some of the ways by which the effectiveness of activities for the aging can be measured.

Copies may be obtained for 35¢ from Mrs. George Heitler, 568 Rockville Court, Oceanside, Long Island, N. Y.

In *Community Programs for Mental Health* (to be reviewed in a later issue of MENTAL HYGIENE), experts view mental health promotion, its underlying theory, typical practices, and evaluation problems. Ruth Kotinsky and Helen L. Witmer edited the book for the Commonwealth Fund. It is available from Harvard University Press for \$5.00.

A new book, *The College and Student Health*, has resulted from the Fourth National Conference on Health in Colleges. Sponsored in New York City last spring by 46 national health and education agencies,

including the National Association for Mental Health, the conference brought together college presidents, deans, physicians, nurses, psychologists, specialists in physical education, recreation, health education, and safety, student counselors, and students themselves to consider ways of improving student health.

The book answers some of the questions they raised about the brilliant student who hasn't learned to keep his academic pursuits within his physical limits, the average student who wears himself out trying to keep up intellectually and socially, the working student who embarks on a suicidal program of courses and jobs, the student exposed to hazards whether on the football field or in the laboratory, the student who ignores or has never learned fundamental health habits, and the student whose emotional problems interfere with his academic life.

Attacking the point of view that college students should be mature adults able to take complete responsibility for their behavior, the book points out that more than half a million are 17- and 18-year-olds away from home and parental guidance for the first time.

Written by Ethel L. Ginsburg and published for the conference by the National Tuberculosis Association, the book outlines essential health services including admission medical exams, health supervision and treatment of illness, counseling, provision of a safe and healthful environment, physical education and recreation, health education, and mental hygiene.

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SOCIAL ADJUSTMENT OF PATIENTS IN THE COMMUNITY THREE YEARS AFTER COMMITMENT TO THE BOSTON PSYCHOPATHIC HOSPITAL¹

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DURING recent years at the Boston Psychopathic Hospital, somatic treatments, milieu therapy, psychotherapy, and psychiatric social work have been accompanied by a large increase in the proportion of committed psychotic patients returned to the community. Further development and wider application of these treatment methods at this and other mental hospitals can reasonably be expected to result in the discharge of nine-tenths of the patients committed to mental hospitals for functional psychosis. This prospect makes imperative a shift of psychiatric interest from custodial care to the question of the ex-patient's social adjustment in the community.

The study reported here centers entirely on the social adjustment of the ex-committed patient. It does not deal with the ex-patient's mental status. The subjects of the study were interviewed by an investigator who was not especially trained in psychiatric interviewing but whose background was largely sociological. The method used for ascertaining the patient's social adjustment was developed through the collabora-

¹ The authors wish to thank Miss Esther Cook, head social worker at the Boston Psychopathic Hospital, for her helpful criticism during the development of this paper, and Mrs. Edna Barrabee, M.S., for her suggestions and valuable instructions in the administering and scoring of the Barrabee-Finesinger Social Adjustment Scale.

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tion of a sociologist, a psychiatric social worker, and a psychiatrist. The goal of this method, and of this study as a whole, was to determine the ex-patient's performance as a member of the community. No distinction was made between ex-patients who were asymptomatic in a psychiatric sense and those who had symptoms. As such, the results of this study do not indicate the results of treatment in the strict medical sense of the term. They do, however, reflect in some measure the results of hospitalization as a learning experience in the art of human relations.

METHOD

The problem of evaluating the social adjustment of ex-patients without injecting the usual psychiatric preoccupation with diagnosis and symptomatology was solved by adopting a method which had already proved its usefulness in evaluating the social adjustment of patients treated for cardiac illnesses. This method—the Barrabee-Finesinger Social Adjustment Scale²—was particularly advantageous since two of its authors were available for consultation and instruction in its use.

Information was obtained from the patients by direct interviews which took an hour to an hour and a half. The interview covered:

*Occupational Adjustment.*³ Each patient was asked to give an account of his work history since his discharge from the hospital, such as how many jobs he may have had, reasons for leaving previous jobs, how well he got along with employer and other employees, his ability to work at the job, his ability to work a full day, his need to take days off from work, and his degree of satisfaction with his job.

Economic Adjustment. This category was based upon financial independence of the patient according to the rate of pay received and the presence of financial strain upon him and his family.

Family Adjustment. Many areas were covered in this section, such as adjustment to parents, siblings, spouse, and

² Barrabee, Paul; Barrabee, Edna; and Finesinger, Jacob E. Barrabee-Finesinger Social Adjustment Scale, 1952. Accepted for publication in the *American Journal of Psychiatry*, 1954.

³ Housewives and students were rated according to their performance at home and in school.

children, sexual performance, performance of home responsibilities, and the nature of relationships. The affect in each of these areas was discussed in detail. This section was divided into two parts, one related to marital adjustment and the other to adjustment of single people.

Community Adjustment. Here the patient was asked the number of friends he had, how much socializing and what kind of socializing he did with them. Information was obtained as to whether or not he made use of or participated in the available community activities and organizations. The affect pertaining to these adjustments was also recorded.

The data gathered regarding each of these four major areas of social adjustment is quantified by assigning scores to items in sub-areas within each major area. Weights are assigned to each sub-area in accordance with the criteria of the scale. The score for each major area is derived from those sub-scores. The numerical value of the score in each major area indicates its position on a five-point scale ranging from five, "very satisfactory," to one, "very unsatisfactory." The position of the score in each of the four areas of social adjustment permits presentation of the individual's social adjustment as a profile. For the purpose of illustration we shall assume that a hypothetical patient received the same score of either 1, 2, 3, 4, or 5 respectively in all four areas. His social adjustment would be described as follows:

1. Very unsatisfactory social adjustment: unemployed. Financially completely dependent, assumes no responsibility in the family, no socialization in the community. Affect in all four areas very disturbed or very dissatisfied.

2. Unsatisfactory social adjustment: employed a quarter of the time or sheltered part-time, changes jobs for poorer jobs, considerably dependent financially, shares very little of the home responsibilities, rarely participates in community or social activities. Affect in all four areas disturbed or dissatisfied.

3. Barely adequate social adjustment: employed half-time or sheltered full-time, changes for equal jobs or for poorer jobs. Slightly dependent financially or financially dependent with strain. Shares a fair part of his home responsibilities. Occasionally participates in community or social activities. Affect in all four areas neutral.

4. Satisfactory social adjustment: employed three-fourths of the time, changes for equal jobs, financially independent but not affluent, assumes home responsibilities, often participates in community or social activities. Affect in all four areas pleased or satisfied.

5. Very satisfactory social adjustment: working full-time, changes only for better job, financially independent and affluent, assumes and performs home responsibilities adequately and efficiently, very often participates in community and social activities. Affect in all four areas very pleased or very satisfied.

The method used for contacting ex-patients was suggested by Edna Barrabee, namely, that of sending a registered letter and requesting a return receipt. An addressed postcard was enclosed in the letter asking the ex-patient to check whether or not he would keep the appointment made for him in the letter. If the postcard was not received from the ex-patient within a few days he was called on the telephone and again asked to keep the appointment.

MATERIAL

The subjects of this social adjustment follow-up study were ex-patients who were in the community three years following the date of their commitment to the Boston Psychopathic Hospital in 1949. The average length of stay in the hospital during this admission in 1949 was 90 days. The average follow-up period from date of discharge was two years and nine months. They include those patients who had been returned to the community from the Boston Psychoathic Hospital and had been discharged from the hospital following the successful completion of one year's "visit" in the community. They do not include those patients who were transferred from the Boston Psychopathic Hospital to other state hospitals and were subsequently discharged to the community. The subjects in the study number 144. Table 1, column E shows their classification by diagnosis. Column A indicates the *original* group of admissions from which they were drawn, and Column B indicates the subsequent "dischargee" group from which they were drawn. Columns C and D indicate the number of "dischargees" who had relapsed and were in mental hospitals or who were dead at the 3-year point (24 and 4 respectively).

TABLE 1. RESULTS OF 3-YEAR FOLLOW-UP OF PATIENTS COMMITTED TO THE BOSTON PSYCHOPATHIC HOSPITAL IN 1949

	A	B	C	D	E
	No. Com- mitted to Hospital	No. Dis- charged from Visit	No. in Mental Hospital at 3-Year Point *	No. Dead at 3-Year Point *	No. in Community at 3-Year Point
Schizophrenia	118	82	16	1	65
Affective psychoses.	79	64	5	1	58
Psychoneurosis	7	5	0	0	5
Organic psychoses..	41	21	3	2	16
Totals	245	172	24	4	144

* Of the number discharged from visit (Column B).

Table 2, Column B indicates the number of ex-patients who responded to our request to make an appointment with us and participated in being interviewed with respect to their interpersonal relations and social adjustment. Interview data were obtained from 65 patients. Table 2, Column C indicates the number of ex-patients who did not keep appointments but who gave information about themselves by mail or telephone or whose relatives or social workers provided information. Non-interview data were obtained from 41 ex-patients. The total number of ex-patients on whom data were obtained was 106 (74 percent of the 144 who were in the community at the three-year follow-up point). The remaining 38 ex-patients were divided equally between those whose address could not be discovered and those who preferred not to be interviewed or

TABLE 2. RESULTS OF ATTEMPTS TO INTERVIEW EX-PATIENTS IN COMMUNITY AT 3-YEAR FOLLOW-UP POINT

	A	B	C	D	E
	No. in Com- munity at 3-Year Point	Informa- tion Ob- tained by Interview	Information Obtained Other Than by Interview	Patient Did Not Respond	Patient Could Not Be Located
Schizophrenia	65	30	18	9	8
Affective psychoses.	58	29	15	7	7
Psychoneurosis	5	2	2	1	0
Organic psychoses..	16	4	6	2	4
Totals	144	65	41	19	19

to give information about themselves (see Table 2, Columns D and E).

RESULTS

The results of this study are conveyed most clearly by dividing the material in two parts: (A) occupational and economic adjustment, and (B) family and community adjustment.

The significance of the data having to do with occupational and economic adjustment is more readily recognized by separating the patients studied into four categories based on their willingness or unwillingness to be interviewed and on the occurrence or non-occurrence of relapse and re-hospitalization during the three-year period. Table 3 gives account of the occupational and economic adjustment of patients in each of these categories.

TABLE 3

	<i>Number of Patients</i>	<i>B-F Occupa- tional Score</i>	<i>B-F Economic Score</i>
(1) Submitted to interview; no relapse.....	45	4.0	2.9
(2) Submitted to interview; had had relapse..	20	3.3	2.6
(3) Did not submit to interview; no relapse..	33	3.6	2.7
(4) Did not submit to interview; had had re- lapse	8	2.8	2.3
Total	106	3.7	2.7

We call attention to the fact that much more detailed and accurate information was obtained about patients in categories (1) and (2) (patients who were interviewed) than about non-interviewed patients (3) and (4). Information about the latter was obtained indirectly from relatives or social workers and was converted into an estimated Barrabee-Finesinger adjustment score.

Inspection of Table 3 discloses that taken as a whole the patients studied made an average B-F occupational score of 3.7, meaning that they were achieving better than a "barely adequate" and very nearly a "satisfactory" adjustment. Their average economic score, however, was 2.7, which indicates that they were achieving an economic adjustment which was less than "barely adequate." We can say then that the "average" ex-patient was getting along

quite well in his job but was experiencing definite stress in maintaining financial independence.

As might be expected, the highest scores in both occupational and economic adjustment were made by the "non-relapsers." It might be mentioned that the superiority of the "non-relapsers" over the "relapsers" in these areas maintained itself among both the interviewed and the non-interviewed patients.

Comparison of the Barrabee-Finesinger occupational adjustment scores achieved by patients classified by sex and admission status is shown in Table 4. The scores of patients whose 1949 admission was either a first or a re-admission had very little spread, namely, 3.7 and 3.4 respectively. The scores of males and females had a still smaller spread, 3.7 and 3.5 respectively. The only significant difference to be noted is that between re-admitted males and females. Here the scores were 4.0 and 3.0 respectively. The higher score achieved by re-admitted males probably indicates that the latter represent a more stringent selection of first-admission patients discharged to the community than in the case of females. We suggest that socio-economic factors influence both the hospital and the families of patients not to sanction discharge of male patients to the community unless they have made a convincing "come-back." Comparatively speaking, there is greater willingness to return females to the community whose "comeback" has been something less than complete. The finding that first-admission females achieved a better score (3.9) than first-admission males (3.5) would seem to contradict this interpretation. On the other hand, this finding can be invoked to support the contention that the re-admitted females represent a selection of patients who did the poorest in a protecting home environment and that the re-admitted males represent a selection of patients who again broke under the relatively greater stress of an unprotecting work environment.

Comparison of the average Barrabee-Finesinger occupational adjustment scores achieved by patients classified by diagnostic syndrome is shown in Table 5. The scores of affective and psychoneurotic patients (3.9 and 4.2 respectively) were significantly higher than those of the organic and schizophrenic patients (3.0 and 3.2 respectively). The differ-

TABLE 5. BARRABEE-FINESINGER OCCUPATIONAL SCORE BY DIAGNOSTIC SYNDROME

	Schizophrenic			Affective			Organic			Psychoneurotic		
	No. Pts.	Average B.F.O.S.		No. Pts.	Average B.F.O.S.		No. Pts.	Average B.F.O.S.		No. Pts.	Average B.F.O.S.	
(1) Submitted to interview; no relapse.....	19	3.1		22	4.4		2	3.0		2	3.5	
(2) Submitted to interview; had had relapse...	11	3.3		7	3.5		2	2.0		0	0.0	
(3) Did not submit to interview; no relapse....	16	3.4		10	3.7		6	3.3		1	5.0	
(4) Did not submit to interview; had had re- lapse	2	2.5		■	2.6		0	0.0		1	5.0	
	—	—		—	—		—	—		—	—	
Total	48	3.2		44	3.9		10	3.0		4	4.2	

(Grand total = 106)

ence between the schizophrenic patients and those with affective disorders is the greatest in category (1) who submitted to interview and had had no relapse during the follow-up period. The score difference is between 3.1 and 4.4. The highest score of the patients with affective disorders may be in part related to the fact that they spend less time in the hospital due to the rapidity with which electric shock interrupts the psychosis. The schizophrenic patients on the other hand spend a longer period in the hospital because their treatment, whether insulin-coma or psychotherapy, is more prolonged. The longer period of hospitalization in the case of schizophrenics is a factor which minimizes their chance of returning to the jobs they had before the onset of their psychosis.

Comparison of the Barrabee-Finesinger economic adjustment scores achieved by patients classified by sex and admission status is shown in Table 6. The difference in average scores here is not as great as in the case of the occupational adjustment. However, they indicate that here again re-admitted males do better than first-admission males, that first-admission females do better than re-admitted females. This suggests that re-admission selects men and women on opposite bases; namely, it selects the most adaptive of males and the least adaptive of females as described under occupational adjustment.

Comparison of the Barrabee-Finesinger economic adjustment scores achieved by patients classified by diagnostic syndrome is shown in Table 7. Here the difference in scores is small or probably not significant. Yet their rank comparison places patients with psychoneurosis and affective disorder above patients with organic and schizophrenic disorders.

FAMILY AND COMMUNITY ADJUSTMENT

Family adjustment and community adjustment could not be adequately investigated except for the 65 patients who were interviewed. Data obtained indirectly on the remaining 41 patients of the 106 were insufficient to determine scores on the Barrabee-Finesinger Scale.

Comparison of the family adjustment scores achieved by patients classified by sex and admission status is shown in

TABLE 6. BARABEE-FINESINGER ECONOMIC SCORE BY ADMISSION STATUS AND SEX

	1st Ad. Males			Re-Ad. Males			1st Ad. Females			Re-Ad. Females		
	No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.	
(1) Submitted to interview; no relapse.....	15	3.0		4	3.0		17	2.9		9	3.0	
(2) Submitted to interview; had had relapse...	5	1.8		3	3.0		7	3.1		5	2.4	
(3) Did not submit to interview; no relapse....	16	2.7		5	3.2		5	3.2		7	2.3	
(4) Did not submit to interview; had had re- lapse	3	2.3		3	2.3		1			1	3.0	
Total	39	2.6		15	2.9		30	3.1		22	2.6	

(Grand total = 106)

Average score of all 1st Ads. = 2.8

" " " " Re. Ads. = 2.7

" " " " Males = 2.7

" " " " Females = 2.9

TABLE 7. BARRABEE-FINESINGER ECONOMIC SCORE BY DIAGNOSTIC SYNDROME

	<i>Schizophrenia</i>			<i>Affective</i>			<i>Organic</i>			<i>Psychoneurotic</i>		
	No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.	
(1) Submitted to interview; no relapse.....	19	2.6		23	3.0		2	2.0		2	3.0	
(2) Submitted to interview; had had relapse...	11	2.5		7	2.7		2	3.0		0	0.0	
(3) Did not submit to interview; no relapse....	16	2.6		10	2.8		6	2.7		1	4.0	
(4) Did not submit to interview; had had re- lapse	2	2.0		5	2.6		0	0.0		1	2.0	
Total	48	2.5		44	2.8		10	2.6		4	3.0	

(Grand total = 106)

TABLE 8. BARRABEE-FINESINGER FAMILY ADJUSTMENT SCORE, BY ADMISSION STATUS AND SEX

	1st Ad. Males			Re-Ad. Males			1st Ad. Females			Re-Ad. Females		
	No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.	
(1) Submitted to interview; no relapse.....	15	3.6		4	3.5		17	3.6		9	3.3	
(2) Submitted to interview; had had relapse...	5	2.5		3	3.5		7	2.9		5	2.7	
Total	20	3.3		7	3.5		24	3.4		14	3.1	

(Grand total = 65)

Table 8. Here again the most significant finding is the better score (3.5) of re-admitted males compared to that of re-admitted females (3.1). This finding supports our contention that re-admission tends to select more adaptive males and less adaptive females.

The community adjustment scores achieved by patients classified by sex and admission status are shown in Table 9. All groups except re-admitted females have scores very close to adequate (which is 3.0). The latter have a score very close to poor (which is 2.0). This low score is consistent with the comparatively poorer scores made by this group of patients in all the adjustment areas.

Comparison of the family adjustment scores achieved by patients classified by diagnostic syndrome is shown in Table 10. The numbers of patients included under organic psychosis and psychoneurosis are too small to warrant comment. The higher score achieved by patients with affective psychosis as compared with schizophrenic patients may be attributed to the fact that affective disorders are more understandable to families and people in general than the schizophrenic disorders. In view of this, it is noteworthy that the family adjustment of the schizophrenic group was adequate (score 3.0).

Community adjustment scores achieved by patients classified by diagnostic syndrome are shown in Table 11. Again the numbers of patients with organic psychosis and psychoneurosis are too small to warrant comment. As was the case with family adjustment, patients with affective disorders achieved a higher score than patients with schizophrenic disorders. It is noteworthy that the affective group did not make a better score than adequate (3.0). The poor community adjustment of the schizophrenic group is more in accordance with clinical expectations.

Comparison of Social Adjustment of "Relapsers" and "Non-Relapsers."

The social adjustment scores of 20 patients who had a relapse during the three-year follow-up period and of 45 patients who had no relapse are shown in Table 12. It is immediately apparent that the "relapsers" have a poorer rating in all four areas of social adjustment than the "non-relapsers."

TABLE 9. BARRABEE-FINESINGER COMMUNITY ADJUSTMENT SCORE BY ADMISSION STATUS AND SEX

	1st Ad. Males			Re-Ad. Males			1st Ad. Females			Re-Ad. Females		
	No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.	
(1) Submitted to interview; no relapse.....	15	3.2		4	2.9		17	3.0		9	2.4	
(2) Submitted to interview; had had relapse...	5	2.0		3	2.8		7	2.4		5	1.7	
	—	—		—	—		—	—		—	—	
Total	20	2.9		7	2.8		24	2.8		14	2.2	

(Grand total=85)

TABLE 10. BARRABEE-FINESINGER FAMILY ADJUSTMENT SCORE BY DIAGNOSTIC SYNDROME

	<i>Schizophrenia</i>			<i>Affective</i>			<i>Organic</i>			<i>Psychoneurotic</i>		
	No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.	
(1) Submitted to interview; no relapse.....	19	3.1		22	3.9		2	3.8		2	3.3	
(2) Submitted to interview; had had relapse...	11	2.9		7	3.0		2	2.3		0	0.0	
	—	—		—	—		—	—		—	—	
Total	30	3.0		29	3.6		4	3.0		2	3.3	

(Grand total = 65)

TABLE 11. BARABEE-FINESINGER COMMUNITY ADJUSTMENT SCORE BY DIAGNOSTIC SYNDROME

	Schizophrenic			Affective			Organic			Psychoneurotic		
	No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.		No. Pts.	Average B.F.E.S.	
(1) Submitted to interview; no relapse.....	19	2.6		22	3.3		2	3.4		2	2.2	
(2) Submitted to interview; had had relapse...	11	2.2		7	2.2		2	1.9		0	0.0	
Total	30	2.4		29	3.0		4	2.9		2	2.2	

(Grand total = 65)

TABLE 12. BARRABEE-FINESINGER SOCIAL ADJUSTMENT SCORES OF "NON-RELAPSEES" AND "RELAPSEES"
(based on 65 ex-patients who were interviewed)

<i>Occupational Adjustment</i>		<i>Family Adjustment</i>		<i>Community Adjustment</i>		<i>Economic Adjustment</i>	
Average Score of 45 "Non- Relapsers"	Average Score of 20 "Relapsers"	Average Score of 45 "Non- Relapsers"	Average Score of 20 "Relapsers"	Average Score of 45 "Non- Relapsers"	Average Score of 20 "Relapsers"	Average Score of 45 "Non- Relapsers"	Average Score of 20 "Relapsers"
4.0	3.0	3.5	2.8	2.9	2.2	2.9	2.6

Both groups of patients have their best rating in occupation adjustment and their next best rating in family adjustment. The "non-relapsers" have the rating 2.8 in both community and economic adjustment, a rating which is slightly less than "barely adequate."

The lowest score of the relapsers is in community adjustment. This score, 2.2, is very near "unsatisfactory" and for that reason is of particular significance. It not only identifies the area of social adjustment in which the relapsers had the greatest difficulty, but its absolute numerical value in the Barrabee-Finesinger Scale is one which indicates an unsatisfactory level of adjustment as theoretically conceived by the authors of the scale in terms of deviation from the social norm. As such, this score suggests that clues to the factors underlying need for re-hospitalization of ex-patients of mental hospitals are more likely to be found through study of the community relations of the ex-patient than of his occupational or family relations *per se*.

More thorough investigation of the social adjustment data collected in this research by comparing sub-groups of patients reveals that two sub-groups deviate notably from the pattern described above. The re-admitted males who relapsed did not have social adjustment scores which differed from those of the non-relapsers. The small number of patients involved (seven in all) detracts from the significance of this deviation. Schizophrenic patients who relapsed also had social adjustment scores which did not differ markedly from those of patients who did not relapse. Here again the lowest rating is in community adjustment and very near the "unsatisfactory" level.

Comparison of the social adjustment scores of patients with affective psychoses with those of schizophrenic patients demonstrates that the scores of the relapsers in these two diagnostic categories are much alike in both pattern and absolute level. The non-relapsers in the two categories, however, present a marked contrast. The non-relapsing patients in the affective category have much higher ratings in all the areas of social adjustment, especially in the occupational and family areas. These findings suggest that the factors underlying the problem of relapse with ex-patients who had affective psy-

choses are more clear-cut than with ex-patients who were schizophrenic. In both cases, community adjustment occupies a position of importance as an area of critical difficulty. But with the ex-schizophrenic patients the difference in level of community adjustment between relapsers and non-relapsers is not great. This would seem to suggest that the factors underlying the relapse of ex-schizophrenics may not be reflected in the social adjustment scale to the extent that they are in the case of affective disorders.

Throughout this study community adjustment has emerged as the area of major difficulty for the ex-patient. It is of equal significance that in every sub-group of patients occupational adjustment ranks the highest of all the areas of social adjustment. This suggests that in our society as it is constituted today (at least in the Boston area and for ex-patients of the Boston Psychopathic Hospital) the ex-patient more frequently experiences satisfaction in getting and having a job than he does frustration. It is noteworthy in this connection that 85 (80 percent) of the 106 ex-patients (on whom we had information) were working at the three-year follow-up point.

The evidence that work-relations are more a satisfaction than a stress and that other community relations are more a stress than a satisfaction to ex-patients suggests that mental health programs can profit from giving more attention to the study of problems involved in facilitating the participation of ex-patients in community life.

SUMMARY AND GENERAL COMMENT

The over-all results of this study of social adjustment of ex-patients of the Boston Psychopathic Hospital indicate that on the average patients who are in the community at a three-year follow-up point are making an occupational adjustment which approaches the level of "satisfactory" and a family adjustment better than "barely adequate" as determined by the Barrabee-Finesinger Social Adjustment Scale. Their community and economic adjustment, on the other hand, is a little less than "barely adequate." It would appear from these results that the ex-patients studied are "getting along" about as well as might be expected of the average citizen.

The additional finding was made that ex-patients who have

a history of re-hospitalization since their discharge from their 1949 admission also have a poorer level of social adjustment than those who had no relapse. It was found, furthermore, that the relapsers' lowest score was in community adjustment, the only area of social adjustment in which the score approached the low level of "unsatisfactory."

The results also indicate that the ex-patients in this study experience more satisfaction than stress in connection with their occupations.

A point of interest which emerged in the course of this investigation is that "relapsers" are characterized by a history of getting and losing jobs more than the "non-relapsers." This in itself lowers their occupational adjustment score in the Barrabee-Finesinger Scale. As would be expected, these ex-patients also suffer considerable economic strain both from the frequency of job changes and the loss incurred from re-hospitalization. It should be noted here that even though the "relapsers" had frequent job changes, their highest social adjustment score was in the area of occupation.

The superiority of the ex-patient's occupational and family adjustment compared to his community adjustment is to be attributed in part to the extensive amount of social work which is done in behalf of patients committed to the Boston Psychopathic Hospital. More specifically, it is a reflection of the effectiveness of a social work program which begins preparation for the patient's discharge from the day of his admission to the hospital. On the other hand, it is due in part to the hospital's policy of granting patients the freedom to hunt for work prior to their release from the hospital.

It is pertinent also to suggest that the better occupational and family adjustments of ex-patients are the result of social work policy of focusing on the problem of occupation and family relations. Conversely, the poor community adjustment *may* be related to the social worker's relative lack of resources in the area, or to a social work policy which does not include investigation and correction of the patient's community relations.

The relatively poor economic adjustment of the ex-patients in this study as compared with their occupational adjustment is to an important degree due to their dissatisfaction with their ability to pay the debts incurred during hospitalization. The

longer the patient's period of hospitalization, the larger the debt he faced on discharge.

A by-product of this study is the observation that the sequential pattern of "breakdown" in psychosis begins typically in community life with withdrawal from recreational and social activities. This is followed by the appearance of difficulties in the occupational life and a subsequent cessation of going to work. Cessation of work is followed in turn with exacerbation of difficulties in family life, often accompanied by economic problems, which culminate in commitment to the mental hospital. The "build-up" process, concomitant with and continuing after treatment, begins with cementing family relationships, along with week-end visits to the home, and with finding a job, frequently prior to release from the hospital. These are followed in turn by improvement in economic conditions and finally by re-entry into community social and recreational activities. The latter appears to be a most crucial and most difficult step toward complete recovery. The question of whether success or failure in executing this step is to be attributed to the intra-psychic pathology of the individual or to the social context in which he lives is one which can be answered only by further research.

Research which depends on contacting and interviewing ex-patients requires that considerable forethought be given to the manner in which they are to be approached. In this study, many patients and families were responsive and cooperative. Other patients were suspicious and hostile while their families welcomed the chance to discuss with the interviewer their problems involving the ex-patients. And in other cases, both the family and the patient successfully resisted all efforts to obtain an interview with them. Some were annoyed at the method used to establish whether they received our letter or not: namely, that of sending them a registered letter and requesting a return receipt.

The experience of this study suggests that a fuller knowledge of the course of mental illness following treatment depends on obtaining frequent contacts with patients over a period of many years beginning soon after the time of their release from the hospital.

SOME PSYCHOLOGICAL PROBLEMS OF THE INCIPIENT ARTIST

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IN an exceedingly perceptive series of articles^{2, 3, 4} Hutchinson has analyzed the psychological reactions of artists and other creative persons as they grapple with their emergent work. Thus, he describes the period of incubation of ideas, the throes of inarticulation, and the rapture of discovery. The validity of his observations is supported by other investigators⁵ as well as the artists themselves.⁶

While findings of this sort have shed much light on the creative process *per se*, they have not touched upon some of the emotional difficulties which may be evoked by a change of role from aspirant to artist. For such a change often arouses fears which are related to unresolved and unconscious conflicts. In this paper, we shall discuss three frequently reported fears which, although they may incapacitate workers in other fields too, seem to have a particularly noxious effect upon the artistic enterprise. We shall refer to these fears as the fear of presumption, the fear of talent, and the fear of inner emptiness.

From the strategic vantage point of a psychotherapist in a university setting,* we were able to follow the inner turmoil of neophyte artists who struggled with these fears during their transition from late adolescence to early adulthood. Occasionally, this transition resulted in the attainment of genuine artistic stature and identity. In others, incipieney threatened to remain a chronic state of being. Finally, the problems of many were resolved by a renunciation of artistic aspirations.

1. The Fear of Presumption

To be an artist, it is necessary to stand as a criterion for oneself and others. Unlike other disciplines, the artistic vocation requires its practitioners to mold reality and experience

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into images of their own creation. This transformation is guaranteed only when the artist can presume freely to interpret things as he sees them, to place the stamp of his perceptions upon the world. In short, the artist does not merely reflect the environment; he also infuses it with meanings which emerge from his uniqueness.

The essence of the artist's task, therefore, demands that he set himself before the unknown and ambiguous world of potential communicants as one whose special endowments permit him to speak rather than listen, to write rather than read, to paint rather than view. In interpersonal terms, the artist assumes a posture of authority with respect to his audience.

For the successful and seasoned artist, this presumption, this role of authority, is no longer an uncomfortable one. Indeed, in many cases, presumption becomes its own reward and grows out of all proportion to any justification for it. Nevertheless, for the incipient artist, the acceptance of this presumptive role may be most difficult.

Unfortunate experiences of childhood and adolescence often convey to the incipient artist the feeling that he is essentially evil or inferior in comparison with others. Once such feelings have been internalized it is impossible for the neophyte to be content with his vocation or creations. For he is split within himself. On the one hand, he feels impelled to create, to express himself through an artistic medium. On the other hand, he feels worthless and guilty whenever he contemplates his artistic relationship to others. In extreme cases, this conflict may result in the production of works which are then either destroyed or kept from public view. Franz Kafka's request that his manuscripts be burned after his death is a striking example of this sort of self-negation.

Paradoxically, inhibitions stemming from the fear of presumption may develop when a person is inwardly or unconsciously so strongly driven by a need to impose his artistic productions on others that he is frightened by the strength and anti-social implications of his drives. Consequently, he tries to protect himself from himself and the world, whose disapproval he expects would follow its discovery of his intense wilfulness, by denying presumption and suppressing the

output of artistic work. Such a person is likely to wear a façade of humble gentility, compliance, and self-effacement.

John R. had precisely this façade. He was a student of design whose work was considered very promising. However, he was never able to bring things to completion, to actualize in detail the ideas and concepts discernible in his initial drawings. Instead, he would sketch out a basic conception and submit it for evaluation as a substitute for the finished product which was patently required. Similarly, in his conversation, he was full of innuendo, trailing sentences, and vague gestures. He would begin a thesis but never get beyond the portents of it.

In psychotherapy it was revealed that his vagueness, his perpetual smile, his soft speech were all part of a deceit; they were, in fact, attempts to make him appear floundering and unassumingly inept. His inner life, however, abounded with fantasies of self-glorification, with almost unimaginable conceit, and with contempt for the ability of his fellow students.

II. The Fear of Talent

To function as an artist it is necessary to commit oneself to one's talent, to acknowledge and develop the creative capacities which one's inner intimations thrust into consciousness. But to support such a commitment the incipient artist must be prepared to accept its consequences: hard work, frustration, responsibility. When he is not so prepared, the existence of his talent threatens him and impels him to turn his back on it. Thus, the very talent which drew him, however tentatively, to artistic endeavor may at the same time arouse his greatest apprehension.

We once treated a girl who reported, among other incapacitating symptoms, an inability to put her thoughts onto paper. Since she desired ultimately to write poetry, her distress may well be understood. Moreover, during our psychotherapeutic sessions, her flow of speech and use of language suggested that her talent was real, if still unleashed.

After several months of treatment, she tried to compose a poem. Much to her surprise, her first line was fluid and beautiful beyond her most wishful imaginings. She jumped up from the desk in what appeared to be a bolt of unrestrained pleasure. Then she proceeded to walk around the room in a

series of excited circles, laughing and talking to herself all the while. Strangely, when the agitation wore off, she found herself to be quite rattled, depressed, and unable to return to her poem.

Upon discussing the incident in our psychotherapeutic interviews, it was apparent that she had been in a frenzy of anxiety rather than in a spasm of joy. Indeed, it was the spontaneous outburst of her own lyricism that filled her with dread. For that single exquisite line meant that she was, or could become, what she had hoped to be. This, in turn, implied that she had to assume responsibility for her talent and its adequate development. Never before had this responsibility been apparent to her. While she had been completely blocked, she luxuriated in her imaginary success without having to work for it. In addition, she indulged herself with extravagant self-pity. It was now clear that all she had ever really wanted to do is to prove that she *could* write poetry. To write steadily, day by day, to suffer the birth pangs of the genuine creative act were not part of the psychological bargains she had made with herself. Hence, when in spite of her inhibitions her creativity emerged, she was overwhelmed by the enormity of its implications

In another case, a young law student consistently refused to exhibit his paintings. He would finish his canvasses, roll them up, and stack them in the recesses of his room. Time after time, his friends, impressed by the quality of his paintings, would suggest ways in which he could offer his paintings for exhibition or sale. But he always countered their suggestions with a host of rationalizations. Some of these seemed very plausible, for example: he was still refining his technique; he was not interested in publicity and money; too much rubbish was already on display: painting for him was merely an emotional catharsis.

Beneath his urbane and disarmingly poised manner, he lived on the edge of desperation. He wanted to acquire a lucrative and prestigious profession. Yet he was unutterably bored with the law and sustained himself largely on the anticipation of the painting which awaited him when he turned away from his texts. However, he had expensive tastes and enjoyed thinking about the amenities of his future position. Finally,

he liked being considered a bright young man by his teachers and fellow students.

Seen in this light, a successful exhibition of his painting and acclaim of his work by professional critics would push him into the whirlpool of his own conflicting values and needs. So long as he could maintain his compartmentalized life pattern, he would not have to face, in any real way, the possibility of giving up his comfortable but insipid legal role for the more hazardous but satisfying artistic one.

III. Fear of Inner Emptiness

In her book, *On Not Being Able to Paint*, J. Field has described in convincing detail the ways in which fear of self-revelation may prevent the artist from working effectively. The artist, like most people, is loathe to bring to light things which have unpleasant or embarrassing implications.

However, some incipient artists are not only afraid of the skeletons in their closet but also of having no closet at all. They fear that their well of inspiration may be pitifully shallow and quick to run dry, that they do not possess enough inner resources to provide them with ore for the artistic castings that they would hope to mold.

The self is the ultimate resource of the artist. If it is blurred and lacking in substance, he has no foundation for his work. From this standpoint both the university milieu and psychotherapy may be transient enhancement of the incipient artist's lifelong search for selfhood.

An aspiring young writer came to psychotherapy with the complaint of obesity. And, as one might guess, it soon appeared that he had some difficulties in writing which were not unrelated to his presenting symptoms. Thus, in spite of the fact that he had already won a number of collegiate literary awards, he was by no means reassured of his ability. On the contrary, he regarded every success as a matter of chance and was convinced that he would run out of literary talent at any moment.

As the case unfolded, a fairly classical psychodynamic picture crystallized. The boy had always felt severely rejected by his parents and had hit upon eating as a source of solace. Since his parents showed great concern over his gain

in weight, his eating also served as a channel for the expression of hostility against them.

He read as voraciously as he ate, books providing supplementary nourishment. Moreover, he used reading as an escape and as a stimulus for an inordinate amount of fantasy by means of which he transformed the frustrating aspects of his life into a procession of unblemished delights.

Although his writing represented a compensatory device, there was no doubt about his actual talent. However, while he felt quite positively compelled to write, he unconsciously looked upon writing as an act of giving. And giving was repugnant to him because his basic orientation to the world was receptive. He saw himself largely as a hollow shell—frightened, deprived, and shaky. Hence, he recoiled from literary production as an expenditure of substance which he did not have or could ill afford to lose.

In quite a different case, we found the fear of inner emptiness lodged in the same fabric of negative self-perception. This concerned a graduate student of painting who dreaded nothing more than the prospect of attaining a life situation which would permit him to devote himself fully to his art.

Bill, as we shall call him, was the elder of two children and had always been pampered and overprotected by his mother. She assigned to his younger brother the role of a rough and tumble boy, trying constantly to differentiate between the two by emphasizing the "goodness" (passivity) of Bill and the "badness" (activity) of his brother. As a result of his mother's training, Bill acquired the self-image of a pretty, fragile, and immobile china doll. To him, passivity insured safety, approval by his mother, and the maintenance of an identity distinct from his brother; activity, on the other hand, had the most disturbing implications since he felt it might incur his mother's displeasure and jeopardize the superior position which he enjoyed in contrast to his brother.

Early in elementary school, Bill discovered that he had unusual skill at drawing and that in exercising this skill he could gain the admiration of his teachers and schoolmates. These were discoveries of overwhelming importance to him because for the first time in his life he found an active role which would bring him approval rather than rejection. Since

drawing thus became associated with positive social response, he clung to it tenaciously as the sphere of activity upon which he would base his life.

As he progressed through school and into the university, he gave increasing evidence that his choice of an artistic career rested on solid talent as well as emotional needs. His work was very favorably received and all his instructors agreed that he was gifted. In his last year as an undergraduate, he became an accepted member of an informal circle of the outstanding art students at his university. Nevertheless, for all his progress, his works were not numerous, and he felt that he made only minimal use of the time he had available for painting.

In graduate school, and especially as the time approached for him to leave to take a position as an art instructor at a small college, his output diminished markedly. Upset by this symptom, as well as by a host of other personal difficulties, he applied for psychotherapeutic help.

During the course of psychotherapy, we were able to detect the relationship between his rapidly declining productivity and his negative self-image. It appeared that he was reacting with anxiety and withdrawal to the anticipation of a job in which he would have the opportunity to concentrate on his painting. This appalled him because he visualized a situation in which he would be on his own and separated from the circle of colleagues on whom he had depended for a constant flow of ideas, evaluating standards, and stimulation. Hence, he felt unable to find within himself the perceptions, sensitivity, and imagination from which to produce one painting after another.

Discussion and Conclusion

We have just seen how the fears of presumption, talent, and inner emptiness can cause the incipient artist to falter and stumble on the path to his career. These fears never occur in psychological isolation, and their incapacitating effects may be reduced or strengthened by the presence of other emotional liabilities and assets within the context of the individual's total personality. Moreover, two or more of the three fears may be found in the same individual and in varying degrees.

It should be kept in mind that the individual, artist or not,

always works in a social milieu;* and that this milieu, together with the specific nature of his work, tends to define the rewards, risks, and behavior patterns of any vocational role he may choose to play. Of course, some vocational roles are so clearly and rigidly defined that they leave the individual little outlet, even if he desired it, for imagination, spontaneity, and creativity. Indeed, in many kinds of work, the individual may almost be regarded as an extension of the machine insofar as his movements become stereotyped and coördinated with the simple and repetitious movements of the machine. Under these circumstances, it is the machine that requires, the individual who adapts.

At the opposite extreme of role delineation, artists, whether poets, painters, sculptures, or writers, have no such externally supplied behavioral routine on which to rely. Nor, on the other hand, are they so constrained. It is true, of course, that the media with which they work contain intrinsic limitations: stone is not clay and words are not pigment. But it would be difficult indeed to exaggerate the ambiguities which confront the artist.

Having decided to undertake a work of art, no small decision in itself, it becomes necessary for the artist to set about his task, to fill the hours of his day. Should he enforce a tight schedule, or work sporadically in response to the urgency of inspiration? Is it better to concentrate on one project at a time or divide attention among several? And then, if he is an author, what shall he write? Shall he devote himself to fiction, or is drama his real bent? And if it be fiction, what form, what substance?

Even having made these and a myriad of other decisions about his working role, the artist faces an unending stream of ambiguities which must be resolved as he puts paint on canvas or words on paper. For he must be in constant communication with his inner eye and judge when a dab of paint is an adequate expression of what he sees and when it is not; when to add,

* We do not pretend adequately to cover so complex a topic as the artist's role in society. Nor can we hope to deal fully with the special psychological difficulties inherent in the various art media. Instead, we merely wish to call attention to some of the social and psychological problems that confront the artist even if he is not upset by any of the fears we have discussed.

scratch, dilute, sharpen, erase, or cover over; when, at last, to end.

It would be sufficiently trying if he had to contend solely with the uncertainties of his art. But the artist also has to face grave economic insecurity in our society. Lacking the sponsorship of a private or public patron, the artist has to put his work on the market as a commodity. The competition is fierce and exerts a constant pressure on the artist to make his commodity a salable one. Since his own artistic inclinations may run counter to the fashions of the market-place, the artist is often faced with such conflicting alternatives as abject poverty with integrity versus a moderate livelihood with hypocrisy. Many prefer a compromise which involves earning a living by non-artistic labor and doing honest art work in their free time.

Admittedly, the difficulties which confront the artist as a consequence of his task and social role are formidable. When, however, the incipient artist is burdened additionally by the fears which our cases illustrate, his prospects for ultimate success are likely to be very remote. Hence, preventive treatment in such cases may determine the outcome of the struggle. For insofar as he becomes free of those irrational anxieties which stem from the vicissitudes of his emotional development, the incipient artist can direct a greater portion of his energies toward the resolution of the other and multifarious problems he must inevitably encounter.

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TWO INTERNATIONAL CRIMINOLOGIC CONGRESSES: A PANORAMA*

SHELDON GLUECK†

TWO international gatherings of importance to the study of crime and the improvement of the administration of criminal justice convened in Europe during the summer of 1955. One was the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva August 22 to September 3; the other was the Third International Congress on Criminology, held in London September 12 to 18. The United Nations Congress is a successor to the quinquennial congresses of the International Penal and Penitentiary Commission beginning in 1872; the criminologic gathering is a periodic feature of the International Society for Criminology, a non-governmental organization.

The United Nations assemblage was made up of official delegations appointed by the various governments, observers from invited specialized agencies, representatives of non-governmental organizations, and several relevant categories of persons "participating in an individual capacity," including members of the bar and judiciary and university professors. The criminologic congress was made up of private participants interested in various aspects of the delinquency and crime problems.

Both meetings were prepared for with much care, and the documentation for both was of an exceptionally high order. If any criticisms on this score are to be made they are, first, that the participants were overwhelmed with an embarrassment of riches in the numerous documents involved, and, second, that much of the material to be discussed did not reach the members in sufficient time to be thoroughly studied before the meetings. One of the most useful documents, which digested and discussed the relevant reports prepared or assembled by the secretariat, was compiled by the Federal Bureau of Prisons for use by the American delegation to the Geneva congress.¹

* Part I of a two-part paper.

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¹ *Information for U. S. Delegates to the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders* (mimeographed).

THE UNITED NATIONS CONGRESS

Over 50 of the 85 governments invited to participate in the United Nations Congress sent some 300 official delegates, each delegation having one vote. Hundreds of other interested persons attended on invitation. Preparations for the Congress took considerable time and were carried on not only in New York but in consultative groups in South America, Europe, the Middle East, and Asia. Recommendations digesting the conclusions of the regional conferences were deliberated on by the appropriate sections of the Congress, modified to meet the views of the discussants, and transmitted to the plenary sessions for debate and adoption.

Resolutions and recommendations of the Congress do not, of course, have the force of law; but they can have a powerful influence because of the governmental status of the participants as well as the wealth of learning and experience represented at such international technical assemblages. The resolutions should strengthen the hands of leaders in the correctional field in countries which are still far behind the procession of correctional enlightenment.

The United Nations Congress considered the following topics:

- (1) Standard minimum rules for the treatment of prisoners.
- (2) Selection and training of personnel for penal and correctional institutions.
- (3) Open penal and correctional institutions.
- (4) Prison labor.
- (5) Prevention of juvenile delinquency.

It is obvious that the first four topics form a theoretical and functional whole; the fifth appears to have been brought in as an afterthought. Perhaps the reason for the inclusion of juvenile delinquency in an agenda so heavily loaded with penologic issues involving adults is the tremendous recent interest in children's problems and the belated recognition that the study, treatment, and prevention of child delinquency is the really crucial issue; that while there is considerable room for improvement in the area to which the first four items of the Congress were devoted, the problems there involved have previously received a great deal of discussion in both

national and international gatherings;² and that even with marked improvements in the incarceration and correction of adult offenders the total influx of crime will not be greatly affected unless the wholesale supplier of adult criminalism—juvenile delinquency—is effectively coped with at the source.

The final report of the United Nations Congress will not be available in print for several months. In the meantime, mimeographed versions of the resolutions and recommendations adopted by the Congress, as well as an edited compilation of these, have been issued by the United Nations General Assembly.³ Each set of proposals serves as an annex to a resolution adopted in plenary session at the Congress, which requests the secretary-general to submit the recommendations to the Social Commission of the Economic and Social Council for approval; expresses the hope that they will be approved by the Council; provides that they be transmitted to the various governments with the recommendation that favorable consideration be given to their adoption; and that they be given the widest publicity by the secretary-general.⁴

It would require too much space to detail the numerous conclusions of what was a very busy Congress. The following are among the points of major interest.

I

The first section adopted a series of humane Rules for the treatment of prisoners in institutions.⁵ While general stand-

² See, for example, Glueck, S., "The International Prison Congress of 1930," *MENTAL HYGIENE*, Vol. XV, No. 4, Oct., 1931, pp. 775-790, and Glueck, S., "Pre-Sentence Examination of Offenders to Aid in Choosing a Method of Treatment" (report to the International Penal and Penitentiary Congress, 1951), *Journal of Criminal Law and Criminology*, Vol. 41, No. 6, March-April, 1951, pp. 717-731.

³ U. N. Doc. A/Conf. 6/L. 17, Dec. 1, 1955. Credit is due the general rapporteur, Professor Thorsten Sellin, for the skill with which he wove together the numerous suggestions for recommendations and resolutions.

⁴ The resolutions also express the wish that the governments send information on progress, for publication. There are certain variations among the resolutions, especially the one pertaining to juvenile delinquency which requests the General Assembly to transmit the "Report to the Social Commission of the Economic and Social Council, calling its attention to the necessity of maintaining the priority already given to the question of juvenile delinquency in the program of work of the Social Commission," and recommending that the suggestions be included in the "social defense work program."

⁵ *Standard Minimum Rules for the Treatment of Prisoners*, report by the secretariat, United Nations, A/Conf. 6/C. 1/L. 1; Amendments A/Conf. 6/L. 4.

ards and recommendations for improvement of peno-correctional practices have been set forth in the conclusions of past international congresses,⁶ the Geneva assembly spelled out the standards in detail, modernizing them and converting the platitudinous into the realistic and practical. Only a sampling of the 94 items involved can here be given. At the outset the framers took into account the "great variety of legal, social, economic, and geographical conditions of the world" as making it "evident that not all the Rules are capable of application in all places and at all times," but that they are intended to "stimulate a constant endeavor to overcome practical difficulties in the way of their application, in the knowledge that they represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations."

A basic principle is that the Rules should be applied impartially; that "there shall be no discrimination on grounds of race, color, sex, language, religion, political, or other opinion, national or social origin, property, birth, or other status." At the same time it is provided that "it is necessary to respect the religious beliefs and moral precepts of the group to which the prisoner belongs."

Among the outstanding features of the Rules is the requirement that no person shall be received in an institution "without a valid commitment order" the details of which are to be entered in a bound registration book covering matters of identity, reasons and authority for the commitment, time of admission and release. There shall be segregation of inmates by sex, age, criminal record, legal reasons for detention, and treatment needs. Accommodations should meet detailed health requirements in respect to sleeping, working, and bathing quarters and general sanitation. Wholesome food "of nutritional value adequate for health and strength" should be furnished. Open-air exercise and physical and recreational training should be provided. The services of at least one

⁶ See note 2. The draft of rules considered by the Congress was prepared by the secretariat on the basis of regional conferences on the draft of standard minimum rules adopted in 1951 by the International Penal and Penitentiary Commission, A/Conf. 6/C. 1/L. 1, pp. 4-5, and *Information for Participants*, United Nations General Assembly, A/Conf. 6/Inf. 2, pp. 1-2. The rules "are not meant to be purely optional, but on the contrary to be in the nature of a pledge on the part of prison administrations." *Information for Participants*, *op. cit.*, p. 2.

medical officer with "some knowledge of psychiatry" should be made available at every institution, and there should be prenatal and postnatal care and treatment in women's institutions. A detailed program is set forth for the work of institutional medical officers.

Provisions for discipline and punishment are carefully enunciated, and "inhuman or degrading punishments and use of instruments of restraint" are completely prohibited. Prisoners are entitled to make requests or complaints to the prison administration or judicial authority, and such petitions are to be promptly dealt with. Communication with family, friends, and religious and legal representatives is permitted.

High standards are required for prison personnel (a topic also separately dealt with in another section of the Congress); and it is provided that "so far as possible, the personnel shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers, and trade instructors."

Excellent correctional philosophy is reflected in a number of guiding principles. The aim of imprisonment being "ultimately, to protect society against crime," it is stated that "this end can only be achieved if the period of imprisonment is used to insure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life. . . . To this end, the institution should utilize all the remedial, educational, moral, spiritual, and other forces and forms of assistance which are appropriate and available, and should seek to apply them according to the individual treatment needs of the prisoners," and "should seek to minimize any differences between prison life and life at liberty which tend to lessen the responsibility of the prisoners or the respect due to their dignity as human beings." The always difficult transition from prison to freedom is recognized in the provision that "before the completion of the sentence, it is desirable that the necessary steps be taken to insure for the prisoner a gradual return to life in society . . . the treatment of prisoners should emphasize not their exclusion from the community, but their continuing part in it. Community agencies should, therefore, be enlisted wher-

ever possible to assist the staff of the institution in the task of social rehabilitation of prisoners."

Advanced practices of classification and of individualization of treatment are recommended. Post-institutional aftercare is set forth in detail.

There are special provisions for the mentally ill prisoners, for those awaiting trial and for open correctional establishments.

Discussion.—All in all, the Rules comprise a chart and compass oriented toward the most advanced thinking in the correctional field. Not a few jurisdictions, both in the United States and abroad, have a considerable distance to travel if they would thoroughly implement their correctional attitudes and systems with provisions of which the foregoing are but samples. Some countries will have to change, fundamentally, their penal philosophy, to minimize the retributive and deterrent aspects and maximize the therapeutic and rehabilitative. The draft Rules are intended to be not optional but "in the nature of a pledge on the part of prison administrations." But there is of course neither inspective nor coercive power on the part of any international agency to check on their adoption and on the nature of their implementation in practice. However, the wise provision for the furnishing of technical assistance in the correctional field to governments requesting it may in the long run prove much more efficacious than coercion would be. Even if many of these Rules are not soon adopted, their publication should have the desirable indirect effect of causing a reexamination of fundamental conceptions and misconceptions in penal law from the realistic point of view of judging regimes by practical results in terms of reform versus recidivism.

II

An important *Leitmotif* of the recommendations of the section dealing with the *selection and training of personnel*,⁷ is the statement in a heading that "prison service [is] in the nature of a social service." This is said to be a "new con-

⁷ *The Recruitment, Training, and Status of Personnel for Adult Penal and Correctional Institutions*, report by the secretariat, United Nations, A/Conf. 6/C. 1/L. 2; *Amendments* A/Conf. 6/C. 1/L. 2.

ception . . . reflected in the tendency to add to the staff an increasing number of specialists, such as doctors, psychiatrists, psychologists, social workers, teachers, technical instructors," working together as a team. It is recommended that the full-time institutional staff have the status of non-political civil servants with high qualifications, professional training, and attractive salaries and living conditions. Training prior to final appointment, in-service training, discussion groups, and staff conferences are provided for.

Discussion.—It is obvious that when a state shifts its practices from an essentially retributive-repressive program to one emphasizing human dignity and reformability it must place its correctional apparatus in skilled hands and emotionally well-balanced personnel. Surely, the perplexing task of salvaging human personality and character in cases where parents, teachers, and clergy have apparently failed is one that requires the highest talents and the marshaling of the deepest wisdom that the biosocial disciplines can contribute. A familiar source of failure of reform movements in the correctional field is reliance on a new statute or code or prison structure to solve problems which only human dedication and ingenuity can hope to deal with successfully. This is not to say that the "behavioral scientists" can be expected to "cure" crime through magic nostrums. The chief justification for staffing the correctional agencies with professional personnel is that they represent a deliberate effort to be *thoughtful* in coping with human maladjustments, instead of prejudiced or emotionally biased in angry resentment or superficial sentimentality.

In calling attention to the need for professional staffs in the correctional process the standards adopted by the Congress should strengthen the hand of the pioneers in the improvement of correctional practices in countries where it is still believed that repression is the prime remedy for crime and that professional personnel are not needed because it requires no special psychiatric, sociologic, or anthropologic training to use force. But even in certain American states where some effort is made to modernize the peno-correctional regime, the recommendations, if brought to public attention, should raise questions about whether political affiliation should continue

to be a chief qualification for appointments in the correctional field and whether a state can afford the wasteful luxury of untrained and unenlightened prison personnel. For here, as in so many of the affairs of life, it is not so much statutes, systems, or "set-ups" as human beings who make or break the situation; and Pope's famous couplet holds true, particularly in the government of peno-correctional institutions:

"For forms of government let fools contest;
What'er is best administer'd is best."

III

The recommendations pertaining to open institutions,⁸ that is, those "characterized by the absence of material or physical precautions against escape (such as walls, locks, bars, and armed or other special security guards) and by a system based on self-discipline and the inmate's sense of responsibility toward the group in which he lives," provide that the selection of persons for admission to such semi-free establishments should "be made on the basis of a medico-psychological examination and a social investigation," since "the criterion governing the selection of prisoners for admission to an open institution should be, not the particular penal or correctional category to which the offender belongs, nor the length of his sentence, but his suitability for admission to an open institution and the fact that his social readjustment is more likely to be achieved by such a system than by treatment under other forms of detention." The advantages of the open institution are set forth. It is considered that it "represents one of the most successful applications of the principle of the individualization of penalties with a view to social readjustment," and, since it also has the advantage of counteracting many of the disadvantages of short-term imprisonment, it is recommended that the open system be extended "to the largest possible number of prisoners," subject to the necessary conditions of careful selection of the prisoners and proper management of the institution. Detailed measures are set forth intended to facilitate success under open-institution treatment.

A difficulty frequently encountered in connection with open

⁸ *Open Institutions*, report by the secretariat, United Nations, A/Conf. 6/C. 2/L. 1; *Open Institutions*, recommendations adopted by Section II, A/Conf. 6/L. 2.

establishments is presented by the understandably apprehensive attitude of residents nearby. The recommendation includes the necessity of obtaining "the effective cooperation of the public in general and of the surrounding community in particular for the operation of open institutions." Emphasis is placed on the need of limiting the inmate body to a group small enough to permit of the officers' thorough acquaintance with the character and needs of the individual prisoner.

In addition to the series of pamphlet reports prepared by various national contributors to the symposium on open institutions and to the general report by the secretariat, two are of particular value in supporting the conclusions of the section regarding the value of open institutions as a major facility of the apparatus of correction and in assessing the conditions as to personnel and regime which are necessary for successful operation of the open institution.⁹

Discussion.—The considerable interest of the section and Congress on the value of correctional establishments in which both the mental climate and the physical facilities are symbolic of a belief in the possibilities of therapy and rehabilitation of many offenders is a good antidote to the frequent American emphasis upon fortresses of "maximum security." It is becoming recognized that only a relatively small proportion of prisoners require the steel bars and high wall treatment to which the vast majority of prisoners are unnecessarily subjected. The occasional escapes are not too great a price to pay for the favorable opportunities afforded to many by an open institution for which residents are carefully chosen. Only in this way can the bedeviling internal contradiction in imprisonment be resolved: the incarceration of persons who have demonstrated that they are not sufficiently "socialized" in an artificial, restricted, repressive environment which can only further prevent them from becoming socialized. In an open institution the inmate receives constant practice in balancing his selfish motive to decamp against the responsibility he owes the group to which he belongs and the officers who have expressed their confidence by transferring him to

⁹ *Open Institutions: Selection of Offenders Suitable for Treatment in Open Institutions*, by Jose A. Mendez, United Nations, A/Conf. 6/C. 2/L. 3; *Open Institutions: The Place of the Open Institution in the Penal System and in the Community*, by Sir Lionel Fox, United Nations, A/Conf. 6/C. 2/L. 2.

a relatively free environment. He has the opportunity of wholesome identification with desirable parent-figures. He gets practice in the art of "live and let live" and in the satisfactions that come with group approval.

Both as a fundamental institution for the majority of those imprisoned, and as a proving ground for those en route to freedom via parole, there are great potentialities in various types of professionally staffed open institutions. In many countries and in most of the United States, however, the generous adoption of the philosophy, techniques, and personnel of the open establishment will involve fundamental changes in the punishment provisions of criminal codes, the minimizing of the retributive and deterrent impulsions in the criminal law and the maximizing of the therapeutic and rehabilitative, the increasing of flexibility of sentences both as to time and place, the enhancing of the role of the administrator of the correctional system, and the employment of therapists of various kinds.

IV

The recommendations on the perennial topic of *prison labor* are also essentially in harmony with the most advanced thought in the field.¹⁰ For example, one of the general principles attacks a major evil in existing prison labor systems, in insisting that "the interests of the prisoners and of their vocational training must not be subordinated to the purpose of making a financial profit from an industry in the institution." Some penal institutions are still more concerned with the making of money for the state's treasury than the making of men for the state's welfare. The recommendations hold that "work is not to be conceived as additional punishment but as a means of furthering the rehabilitation of the prisoner, his training for work, the forming of better work habits, and of preventing idleness and disorder."

The state-use system, with compulsory governmental pur-

¹⁰ *Prison Labour*, published by the Department of Economic and Social Affairs, United Nations, ST/SOA/SD/5. (A questionnaire study involving 38 countries.) *Prison Labour: Note on Various Aspects of Prison Labour*, memorandum prepared by the secretariat, A/Conf. 6/C. 2/L. 28. *Prison Labour*, draft resolution submitted by the general rapporteur, A/Conf. 6/L. 9. *Prison Labour*, recommendations adopted by Section II, A/Conf. 6/L. 8.

chase of prison-made goods, is evidently preferred to the private-profit contractual system;¹¹ however, a compromise provision states that "recourse may be had to private industry when sound reasons exist, provided adequate safeguards are established to insure that there is no exploitation of prison labor and that the interests of private industry and free labor are protected." Vocational training is stressed. Trade training is to be adapted to the demands of the free labor market, and trades should be sufficiently varied to permit of fitting occupational instruction to the different qualifications of inmates. Equitable remuneration for prison labor is recommended. "It is desirable that it should be sufficient to enable prisoners, at least in part, to help their families, to indemnify their victims, to further their own interests within the prescribed limits and to set aside a part as savings to be returned to them on discharge."

Certain fundamental issues were left open, and it was recommended that regional consultative groups study such problems as the integration of prison labor with the national economy, remuneration for prison work, "with particular reference to the principle that prisoners should be paid for their work on the basis of normal wages paid in the free labor market," appropriate labor programs for such special prisoners as the mentally abnormal, the "work-shy," and professional classes; work opportunities for prisoners awaiting trial; aid to ex-prisoners in finding work on release.

A very promising resolution was adopted expressing the hope that as a means of facilitating the implementation of the Rules and Recommendations the United Nations will provide technical assistance "to those governments requesting it,"

¹¹ The position on this matter is somewhat ambiguous. The recommendations as adopted by Section II (August 31, 1955), dealing with prison labor (A/Conf. 6/L. 8), state that when adequate and suitable employment "cannot be organized by private industries or by other means, the state-use system with compulsory government markets may offer a satisfactory solution." The later (December 1, 1955) compilation by the general rapporteur of *Resolutions and Recommendations Adopted by the Congress* (A/Conf. 6/L. 17) states that "it is preferable that this be done under the state-use system with compulsory government markets." In connection with this problem an interesting debate was held at the plenary session when Edward R. Cass, of the American delegation, offered an amendment to the section's resolution. He urged that the state-use system be given preference. On the vote, 15 countries favored the amendment, 14 opposed it, and there was one abstention.

through sending needed experts, establishing institutions for training personnel, organizing seminars, and publishing guides or handbooks "to facilitate the application of the standard minimum rules and the training of personnel."

Discussion.—It is doubtful whether certain of the countries represented at the Congress are in a position to carry out most of the recommendations. Even in the United States of today, the special interests of labor unions and manufacturers tend to clash with what would be a desirable inmate-centered program. It is difficult to see why prison labor is held to compete seriously with free labor if the industries are sufficiently varied.¹² The amount of prison goods produced is very small compared to the total free labor product of the country, and since most prisoners were already at work at the time they committed their crimes it is hard to justify an attitude that by continuing to work in prison they will seriously compete with free labor.

Gradually, there should evolve in many countries a rational and fair solution of the prison labor problem in which (as in the federal and California systems) representatives of organized labor, industry, agriculture, and the public will pool their points of view, bearing in mind that the vast majority of inmates must at all events be freed some time, that members of organized labor and manufacturers' groups form part of that "society" to which ex-prisoners will return for better or for worse, and that it remains true that "Satan finds some mischief still for idle hands to do." In the meantime, the setting of good standards for the prison labor problem should aid prison administrators in persuading legislators of the need of healing a major sore spot in the correctional field by bringing about constructive use of the inmates' working time.

¹² "Although the issue of competition is not currently an active one in general, the data presented above, when considered in conjunction with information contained elsewhere in the report, indicate that most of the states of Europe, North America, and Oceania have either capitulated to those raising complaints of competition by extensive modification of their prison labor programs, or have achieved an uneasy truce with the complainants, the existence of which is contingent upon continuation of high levels of employment and of economic stability. It would be rash to claim that the problem of the relationships between free labor and industry and prison labor has, in any realistic sense, been solved within the more highly developed countries. The issue may be latent rather than settled." *Prison Labour*, ST/SOA/SD/5, United Nations Department of Economic and Social Affairs, New York, 1955, p. 47.

V

It will be noted even from the partial samples presented above that the recommendations, suggestions, and provisions in respect to the adult offender are commendable, both in reflecting the most seasoned thought and experience in the field of penology and in setting standards which the different governments and correctional agencies within the various countries can measure up to at various stages of progress. It is interesting to note, however, that many of these "advanced ideas" were embodied almost a century ago in the famous "Declaration of Principles" of the American Correctional Association in 1870!¹³

The most important aspect of the work of the Congress, however, was one which is truly fundamental—juvenile delinquency and pre-delinquency—on which an important basic report was prepared in advance by the secretariat.¹⁴ Much time of the section involved was used in getting this aspect of the agenda on the right track, there being at the outset considerable fruitless discussion of the definitions of delinquency. But the resolution and recommendations that finally emerged from the work of the section are important.¹⁵

In its basic resolution, the Congress recognized that much fundamental investigation would have to be done. It was recommended that with the aid of expert non-governmental organizations certain researches be included in the social defense work program of the Social Commission of the Economic and Social Council, among them a detailed study of the methods for prevention of juvenile delinquency, "in two stages": the first to be devoted to the "possibility of organizing a social and health care or guidance system co-operating

¹³ Formerly the National Congress on Penitentiary and Reformatory Discipline, organized in 1870. For an analysis of the Declaration of Principles, see Glueck, S., "Significant Transformation in the Administration of Criminal Justice," *MENTAL HYGIENE*, Vol. XIV, 1930, pp. 280-306; or *Crime and Correction: Selected Papers*, Cambridge, Addison-Wesley Press, 1952, pp. 27-53.

¹⁴ *The Prevention of Juvenile Delinquency*, report by the secretariat, United Nations, ST/SOA/Ser. M/7-8 (Provisional uncorrected edition); *General Principles with Regard to the Prevention of Juvenile Delinquency*, note by the secretariat, United Nations, A/Conf. 6/C. 3/L. 3.

¹⁵ "Prevention of Juvenile Delinquency," recommendations adopted by Section III, A/Conf. 6/L. 11.

closely with the diagnostic services, and assistance to parents, particularly in the task of guidance"; the second, to be an assessment of the "practical value of certain direct and indirect measures for the prevention of juvenile delinquency," by means of regional projects in both developed and under-developed lands.

Another recommended study was an evaluation of the methods of "special police services dealing with juveniles."

The United Nations Regional Consultative Groups and Seminars were urged to continue to devote attention to juvenile delinquency. Organizations planning future congresses and seminars were asked so to select topics as to permit of "useful comparison of the experience acquired in the various countries." This theme of comparative study was emphasized by a number of speakers. The writer, for example, pointed out that through systematic cooperation between researchers in different lands it may be possible to develop a new science of comparative criminology involving investigations which employ standard definitions and methods; that thereby those influences found to be uniform in different countries could be detected, with the way open for a solid science of criminology. This idea was embodied in the list of recommendations comprising the annex to part 5F of the resolutions and recommendations of the Congress, which deals with research.

The deliberations on delinquency became fruitful after the barren search for definitions was replaced by a proposal that "the discussion and study of the Congress should include not only those juveniles who have committed an act regarded as a criminal offense by the law of their country, but also those whose social situation or whose character places them in danger of committing such an act, or who are in need of care and protection"; and it was emphasized that "preventive work should cover all three categories." Without such a comprehensive point of view the discussions, like the usual activities of juvenile courts, would have been confined to situations in which delinquency is already a *fait accompli*, when even at an early age it is extremely difficult to curb. Once the more realistic point of view was adopted by the section on delinquency, it became evident that the most promising approach

was to emphasize *pre-delinquency*. To have a manageable method of discussion it was decided to deal with preventive work with pre-delinquents in the community, the family, the school, and the social services and other agencies, despite the obvious overlap in the classification.

After emphasizing the importance of the community¹⁶ and neighborhood and their influence on behavior "through the family, the school, religious and other social institutions," the conclusions and recommendations point out that community action to prevent delinquency is largely a matter of organizing the numerous local resources (through co-ordinating councils or similar devices) to provide a milieu "in which children may develop without abnormalities of character" and in which "those who are in danger of becoming delinquent may be discovered and guided toward conformity to normal standards." The recommendations that follow include the integration of official and unofficial services for youth to meet the basic needs of early childhood, not only through wholesome and constructive activities of the family, school, and other social institutions, but also by means of child guidance clinics, parental counseling services, constructive leisure time outlets, and special schools.

Selection and adaptation of preventive activities from other countries are recommended, taking account of cultural differences. Special attention to "delinquency areas" is urged. While it is pointed out that programs of "general social welfare are not sufficient by themselves," to dispense with specific policies directed toward the prevention of delinquency, general improvement in urban housing conditions is called for, to "be so organized as to provide for full community living."

In introducing the recommendations regarding the family,¹⁷ it is emphasized as axiomatic that the family is fundamentally important in development of personality, attitudes, and be-

¹⁶ For a careful comparison of delinquents and non-delinquents in the community, and an indication of the kind of recommendations that emerged from such a study, see Glueck, S. and E. T., *Unraveling Juvenile Delinquency*, New York, Commonwealth Fund, 1950, chapters XIII, XXII.

¹⁷ For a careful comparison of the home conditions and family life of delinquents and non-delinquents, and an indication of the kind of recommendations that emerged from such a study, see *Unraveling Juvenile Delinquency*, *op. cit.*, chapters VIII, IX, X, XI, XXII.

havior, and that the impact of industrialization and urbanization has brought about considerable "social, family, and personal disorganization. According to current opinion, delinquency appears to be intimately connected with the social and cultural changes that have operated through the family."

Profiting from experience, it is recommended "that in those societies that are recently becoming industrialized and where the family is still a well-integrated and effective unit of control, serious effort should be directed to maintaining its cohesiveness in order to mitigate so far as possible the disorganizing consequences of industrialization." It is of major importance that "preventive efforts be designed to produce closer family ties, thus achieving greater affection, emotional security, and control through the family." Recognizing the family as the cradle of personality and character, the recommendations embrace provision of material needs to underprivileged households, including children's allowances where required "to keep the family intact," to avoid the necessity of mothers working outside the home and to protect children of broken homes.

Counseling aids for parents and children are recommended. Conciliation devices for estranged parents, as well as psychologic aid to parents, should be provided. Children should, as far as possible, be kept in the family and there be given treatment for emotional and social needs, due process of law being observed when it is necessary to remove children compulsorily. Where the family situation is seriously inadequate, use should be made of foster homes. Placement in special institutions for delinquents should not be resorted to unless children have actually violated the law and supervision in their own homes has failed. Similarly, placement in care-taking institutions should occur only when care in the child's own home or in some foster home is impossible.

In discussing the role of education,¹⁸ it is pointed out that, next to the home, the school is in the most intimate contact with the child up to adolescence, and that it plays an important role, not merely in his intellectual growth but also in his emo-

¹⁸ For a careful comparison of the school life of delinquents and non-delinquents, and an indication of the kind of recommendations that emerged from such a study, see *Unraveling Juvenile Delinquency*, *op. cit.*, chapters XII, XXII.

tional and social development. Among the recommendations for the preventive work of the school is the provision of flexible curricula, to take account of individual differences; the school's playing of a "constructive role in the development of character and attitudes among children, with the object of counteracting unhealthy influences in the community"; provision in the educational program of cooperation between school and family, in order to minimize children's difficulties of adjustment; and the placing of greater emphasis upon vocational guidance and other measures designed to aid adolescents in the transition from school to working life.

In connection with such school activities, it is recommended that the training of teachers should include preparation for understanding the problems of childhood and for discovery of children with emotional or behavioral difficulties, and that teachers should be of the type "with which children can properly identify themselves in the development of their character and goals of living."¹⁹ It is recommended that psychologic and social services attached to the school should be developed to advise both parents and teachers and that guidance clinics and testing and treatment facilities for children be established.

In the part of the recommendations dealing with social services (including health agencies), it is pointed out that "as a consequence of the development of conditions of life in the modern community, the ordinary social institutions, such as the family, school, and religious institutions, have encountered increasing difficulty in the effective performance of their functions. In particular, they have had limited success in maintaining stability, integrity, a sense of independence and responsibility of the individual." It is claimed that the "corollary of such a situation is that more and more juveniles are becoming delinquent and it is also responsible for other forms of emotional and social disorders such as psychoneuroses, psychoses, alcoholism, suicide, family breakdown, unemployment."

For the solution of such problems special social agencies are being increasingly called upon. A "full network of social

¹⁹ "We must properly recognize . . . the role of teachers as parent-substitutes and 'ego-ideals' in the structuring of character." *Unraveling Juvenile Delinquency*, *op. cit.*, p. 288.

and health services" by both official and unofficial agencies is called for where "necessary and feasible," including welfare agencies, psychiatric clinics, family agencies, children's guidance centers, and the like.

Integration and co-ordination of the various community services is necessary to avoid duplication and discover gaps. The co-ordinating agency can determine which type of aid a maladjusted child needs, and serve both as a clearinghouse for cases referred to it by different agencies in close contact with children that require therapy, guidance, or control, and as a central referral device.

Specialized training is required for psychiatrists, psychologists, social workers, probation officers, special school teachers, and others entrusted with children's problems.

Provision should be made for the evaluation of new forms of social action.

There are recommendations also for the development of placement centers for children, legislation for encouraging vocational training, homes, and hostels for juvenile workers and better control of the working conditions of children.

Recommendations were also made regarding the role of various general agencies in the community which are in a favorable position to discover "children who display social or emotional problems." In this connection reference was made to religious bodies, police organizations, and different agencies concerned with constructive use of leisure. As to these general agencies, it was recommended that their activities be integrated more closely into the services and objectives of the other social institutions concerned with the prevention of delinquency.

On the much-debated issue of the influence of cinema, radio, television, and comic books, it was concluded that "more may be gained by a positive emphasis upon the development of constructive and diversified activities . . . than rigid and negative measures of control and censorship."

The final recommendation has to do with the need to advance research, not only to study "causation, prediction, and prevention," but to evaluate the effectiveness of existing preventive measures. "Comparative, co-ordinated, and interdisciplinary research should be carried out to determine the

relative effects of programs in different countries" and "through co-operation between researchers from different countries . . . to develop a highly promising new field of comparative criminology," in order to determine "uniformities and differences in causal influences, in predictive factors, and in results of preventive and treatment programs" and to develop "a true science of criminology." To these ends "the United Nations is urged to continue its support of significant research in these fields."

Discussion.—In all these provisions regarding juvenile delinquency there is nothing startlingly new and nothing that informed students of the problems of delinquency and pre-delinquency would not subscribe to. But one cannot help wondering whether the call for more and more social welfare agencies to put fingers in the holes of the societal dike is enough to hold back the cultural waters that are said to bring on the evils not merely of delinquency but of neurosis, psychosis, alcoholism, and the like. One is reminded of the statement in *Unraveling Juvenile Delinquency*:

"To the extent that general cultural pressures and disharmonies make for antisocial behavior on the part of those who find it difficult, or are unwilling, to conform, we are confronted with a tremendous problem which can be managed only by society and an overall social policy. Basic modifications in the general culture are bound to be slow and are usually unplanned. However, we can take advantage of the fact that parents are to a great extent not only the bearers, but also the selective filters, of the general culture, and thus take steps to mold the under-the-roof culture of the homes of young children around socially desirable goals." ²⁰

A major difficulty with the type of recommendations for the treatment of children's problems adopted by the United Nations Congress derives from the fact that the array of countries represented included on the one hand relatively simple, economically primitive agricultural lands, and on the other the most highly industrialized and urbanized countries the world has ever seen. One can subscribe to the conviction that unwholesome socio-economic conditions which present to the ordinary family in backward lands a desperate elementary struggle for bread and bed are there very relevant to family disintegration, to parental neglect of children, to delinquency. In more developed countries, with a very high

²⁰ *Unraveling Juvenile Delinquency*, op. cit., p. 287.

standard of living, such factors take second place to more subtle and perhaps more serious disturbances of the individual personality and of the family as the matrix of character. In the light of the ease with which colorless, abstract generalizations might have resulted from the wide variety of cultures represented at the Congress it is gratifying that the recommendations which emerged are as specific as they turned out to be. Certainly, they should serve as a warning to those lands now eagerly exploring the glittering El Dorado of an industrialized, mechanized, atom-powered, urbanized way of life, to set up social geiger counters to warn of the necessity of preserving the time-tested values of cohesive family life and affectionate parent-child relationships in the face of the on-rushing transformations of the general culture.

A noteworthy omission in the recommendations is the absence of any adequate discussion and suggestions in respect to the early prediction of delinquency. The preparatory document on juvenile delinquency,²¹ a statement of general principles drafted by an ad hoc advisory committee of experts called together to advise the secretariat states that "specific preventive measures fall into three categories, of which the first two are:

- (i) Prevention by early detection and treatment of potential delinquents before they present a manifest problem.
- (ii) Prevention at the stage of pre-delinquency, i.e., by diagnosis and treatment of the 'problem personality.' "

It would seem that predictive devices for the early screening of potential delinquents should therefore have been hailed as the most valuable techniques of a preventive program. Yet in the document prepared by the secretariat, which in certain respects is a very competent piece of work, the part devoted to prediction (dealt with in connection with discussing causation) is as disappointing as it is non-persuasive. A typical sample of the kind of argument presented in opposition to the prediction technique is the following:

"Even if those juveniles who were predicted to be pre-delinquents or potential delinquents do become delinquents after X number of years reckoned from the original prediction, such results do not necessarily

²¹ *The Prevention of Juvenile Delinquency*, report by the secretariat, United Nations, ST/SOA/Ser. M/7-8, p. 8; reprinted in *International Review of Criminal Policy*, Nos. 7-8, January-July, 1955.

imply a validation of the prediction tables. The reason is that during the intervening years factors other than those originally taken into consideration in preparing the tables may have played a more decisive role."²²

Thus one is asked to ignore specific, clearly defined factors which have been demonstrated to be predictively effective in distinguishing potential delinquents from non-delinquents at a very early age (when timely intervention promises really successful preventive effort) in favor of some mysterious, unidentified factors which *may*, through the long arm of coincidence, account for the results in the case of the delinquents only! It is unfortunate that so patently untenable a discussion of a device which is the most promising approach to effective prophylaxis should receive wide circulation. It can only serve to discourage some workers in foreign countries who might be inclined to accept it at its face value. At one session of the Congress, the writer took occasion to answer the criticisms of predictive methods as screening devices for the early detection of potential delinquents, while Dr. Eleanor T. Glueck reported on the validations of the Glueck Social Prediction Table; and it was evident that considerable interest was aroused in the great promise of such instrumentalities in a realistic program of delinquency prevention. But, the following sentence of item F of part V of the *Resolutions and Recommendations Adopted by the Congress* illustrates the limited formal discussion of prediction: "More important, perhaps, than any of the specific conclusions and recommendations submitted above is the obvious need for the development of more research relating to the definition of the term 'juvenile,' to delinquency causation, prediction, and prevention."²³

A real opportunity was missed, in discussing the rôle of the school in a crime-prevention program, to encourage the development of what promises to be a crucially important device. Since the school is the first testing ground of the child's ability to cope with the systems of prohibitions laid down by society, it is an excellent vehicle for the early identification of symptoms of maladjustment. As was said elsewhere, "In an enlightened educational system, the school could function as the litmus paper of personality maladaptation, reflecting the acid

²² *Ibid.*

²³ A/Conf. 6/L. 17, p. 47.

test of the child's success or failure in his first attempts to cope with the problems of life posed by a restrictive, impersonal society and code."²⁴ A highly promising Social Prediction Table, which was developed in connection with a careful comparative study of delinquents and non-delinquents and published in *Unraveling Juvenile Delinquency* together with two other tables designed to predict delinquency, has already undergone several successful validations on samples of cases other than the ones on which the table was built and is at present being applied, experimentally, by the Youth Service Board of New York City to several schools in underprivileged sections, with a view to testing its efficiency and to determining the value of timely therapeutic intervention in preventing delinquency.²⁵ The school seems to be the most logical agency for the use of such screening devices as part of a widespread prophylactic program designed to nip delinquency in the bud.

It is evident from the recommendations involving juvenile delinquency that the Congress ranged over a wide field of discussion and that, apart from its inadequate treatment of pre-delinquency predictive devices, it took ample account of various approaches to the pressing problem of delinquency prevention. It is hoped that the next United Nations Congress will be devoted fully to the problem of child delinquency, since this is the crucial prologue to the tragedy of adult criminalism.

(to be concluded in October)

²⁴ *Unraveling Juvenile Delinquency*, op. cit., p. 269.

²⁵ Thompson, Richard E., "A Validation of the Glueck Social Prediction Scale for Proneness to Delinquency," *Journal of Criminal Law, Criminology and Police Science*, Vol. 43 (Nov.-Dec. 1952), pp. 451-470; Axelrad, S. and Glick, S. J., "Application of the Glueck Social Prediction Table to 100 Jewish Delinquent Boys," *The Jewish Social Service Quarterly*, Vol. XXX (Winter, 1953), pp. 127-136; Whelan, Ralph W., "An Experiment in Predicting Delinquency," *The Journal of Criminal Law, Criminology and Police Science*, Vol. 45 (Nov.-Dec. 1954); "Predicting Juvenile Delinquency," *Research Bulletin Number 124*, April, 1955, published by the Department of Institutions and Agencies, Trenton, New Jersey. Two other validations were presented in papers at the London Congress: one, by Dr. Augusta Bonnard, involving a follow-up of children examined at the clinic of the London County Council; the second, by Mrs. Ian Brandon, a study of adult sex offenders at Sing Sing Prison. Both indicated high predictive power on the part of the Social Prediction Table. These studies will presumably be published in due course. Another validation, not yet published, is Thompson, Richard E., "Further Validation of the Glueck Social Prediction Scale for Identifying Potential Delinquents" (a study of 50 boys from Boston Juvenile Court and 50 girls committed as delinquents to the Massachusetts Youth Service Board).

THE PSYCHIATRIC INTERVIEW AND TEACHER TRAINING*

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BEGINNING with the winter quarter of 1951, at the request of the School of Education the Student Health Service at the University of Denver initiated a program of physical and psychiatric evaluation of students who were candidates for teaching. These evaluations were made at the time the students entered the education sequence in their junior year or, in the case of transfer students, at the time they entered the university. We are reporting on the psychiatric evaluations of 582 students who were seen between January 1951 and June 1953.

The physical evaluation consisted of a complete physical examination, including audiograms and chest photoroentgens. The psychiatric evaluation consisted of an interview by the psychiatrist who had available, at the time of the interview, results of a group-administered modified Thematic Apperception Test. When the study began, the TAT material was interpreted by clinical psychologists and only their findings of significant pathology were furnished to the psychiatrist. Later this procedure was dispensed with and the raw test material written by the student was used by the psychiatrist as a means of supplementing the interview material.

Each student was scheduled by the School of Education for a specified half-hour appointment with one of the university psychiatrists. A preliminary talk was given during the first week of classes of the quarter in which students would be interviewed. One reason for this introduction was the alarm we expected from students at being requested to see a psychiatrist. The introductory talk consisted of a statement of the goals of the psychiatric evaluation and an explanation of the fact that this was a requirement which had no

* Presented before the American College Health Association, April 30, 1955, at Colorado Springs, Colo.

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reference to their status in the School of Education but a requirement that must nevertheless be completed. It was also explained that material obtained would be treated with medical confidence and no report other than a statement of completion of the requirement would be returned to the administration. Care was taken to inform students that the responsibility of the psychiatrist was to the student and not, as a screening agent, to the School of Education.

The goals we formulated were stated to the group during the introductory talks as follows:

- (1) To provide an opportunity for an educational experience whereby the prospective teacher, using himself as the subject, could learn first-hand something of the structure and functioning of the personality and at the same time acquire certain insights into his own personality with emphasis on his abilities to relate effectively to others.
- (2) To help the student discover the presence of any significant emotional problems at a sufficiently early point in his college career so that therapy could be undertaken, when indicated.
- (3) To counsel with those students patently unsuited to teaching so that they might choose another vocation in which they could be more effective and happier. We thought it was also valuable that the student have the experience of talking with a psychiatrist.

Each student was seen in a private office and, in general, a form was followed. After identifying information was obtained, each student was asked about his specific professional goals and what it was that had attracted him to teaching. Following this, a brief psychosomatic survey was conducted. We attempted to make it clear that in a statement of general health we wanted the student's opinion and not the fact that he had passed a physical examination recently. A brief evaluation of his current life situation followed, including military experience, with questions about adjustment, hospitalization, and any disciplinary action, the work history and adjustment, the nature of living arrangements, the quality of relationships with significant people, the marital history

and/or sexual adjustment, the general level of social activity, and the degree of financial independence. We then specifically explored the general mood with particular reference to feelings of depression and attempted to determine the amount of anxiety experienced in relation to stress situations. Somewhere in each interview, a direct question was posed as to whether or not the student felt he was in need of help with emotional problems. No particular attempt was made to arrive at a diagnostic formulation unless this happened to be the most convenient method of describing the findings.

One might wonder, in a brief contact of this sort, how information about the structure and functioning of the personality can be transmitted. By focusing the attention of the student on his professional goals and motivations, we tried to convey to him the importance of these areas to emotional health. As the psychosomatic survey proceeded, the possible meaning of symptoms as signals of a disturbed emotional economy was explained. Frequently students voluntarily presented for discussion information about those aspects of their current living situation which they regarded as unhealthy. Many of the students had either part-time or full-time employment in addition to their academic schedule, and it was easy to enter into a brief discussion regarding the proper balance of their "emotional nutrition." By inquiring specifically about dating and whether or not the student felt at ease socially, much information was obtained concerning the patterns of behavior to form the basis for discussion. The difference between "normal" anxiety and neurotic or pathologic anxiety was easily demonstrated in relation to the individual's response under stress situations, such as final examinations, public speaking, and social and professional group activities.

For persons who would soon be intimately concerned with the emotional and intellectual growth of children, we felt that the need for a clear orientation as to the role of the psychiatrist in modern medical practice was unquestionable. We also felt it was of value to desensitize individuals regarding pre-formed fears of psychiatry. Misconceptions regarding this area of medicine were by no means differentially less because this was an above-average intelligence group. Such

misconceptions are often rooted in the defense mechanisms with which each of us maintains his equilibrium. Orientation and desensitization were accomplished experientially rather than didactically.

It has been the common experience of university psychiatrists that problems deserving therapy may be ignored or procrastinated until separation from the college scene becomes imminent. This usually leads to an unsatisfactory brief contact in which the psychiatrist can do little other than recommend to the student that he place himself in a position to undertake treatment in the near future. By focusing the attention of the student on his emotional functioning early in his college career, this project made it possible to identify problems while ample time remained to provide opportunity for adequate therapy.

COMMENTS

As we interviewed these students, we became increasingly interested in the factors that motivated them to choose teaching as a career. By far the largest group appeared well motivated—with a genuine desire to teach, a sincere liking for children, and/or a satisfactory group leadership experience. One could often discern a positive identification with the parental role in the person of their own parents or a well-liked former teacher.

A group less positively motivated toward teaching as a career, regarded it more as a means than as an end. This group included students who preferred marriage but would teach until they could marry; those who felt a "teaching certificate is a good thing to have to fall back on," and those who planned to earn their "bread and butter" by teaching while pursuing a primary objective such as music, art, or the theater.

In some students the primary interest was the subject material and not the teaching of it. A not infrequent comment encountered was "what else can you do with a major in history, sociology, anthropology, etc.?" These individuals, having declared a particular major, arrived at teaching secondarily as a means of using the major productively. Actually, academic advisers had recommended this solution in many

cases. In a corollary group was a large number of the physical education majors whose primary interest appeared to be the specific sport in which they excelled and who subsequently were trying to find a way to put this to use.

A much smaller poorly motivated group appeared to be attracted to teaching in an attempt to satisfy neurotic needs. Many of this group were involved in a mechanism which we have labeled "compensatory identification." This implies a process of dual role-playing in which the individual is identified with the recipient and at the same time is the donor. In this way, he hopes to assume a parental position in order to make up for his own serious emotional deprivation incurred in childhood. The psycho-economy of such an operation, by which we mean the intake and output of emotional energies, is seriously in question. Here an adult role is not attained by giving up infantile wishes but instead the adult role is shammed for the precise purpose of gratifying infantile wishes. Giving is, therefore, seriously jaded by the excessive need to receive. Our experience in treating individuals with this type of motivation suggests that initially such teachers do well; they are eager, energetic, conscientious, and idealistic workers who resent no imposition so long as there is an opportunity to improve the welfare of the student. As time passes, however, one may expect that the rewards become gradually more meager; instead of being able to repay to himself the emotional debt from childhood, the individual finds he has drained his own resources without making a very big dent in the attempt at restitution. In such cases, one often sees disillusionment, bitterness, cynicism, boredom, and quiet resignation to a mechanical type of performance.

There were a few students who had little or no motivation for teaching. These were the occupational drifters who were not sure what they wanted or the overly compliant individuals who had been persuaded to undertake an education major by parents or advisers. It was difficult to increase the awareness of some of these individuals since they seemed quite defensively entrenched in their convictions that teaching would provide an answer to their problems.

Is there any direct correlation between good motivation for teaching and a good teacher? We do not know. In our psy-

chiatric interviews we discovered that the well-motivated students were not always the mature and well-adjusted, for in some we encountered such problems as generalized immaturity, over-dependency, excessive hostility, poor sexual adjustment, frequent depression, tension symptoms, psychosomatic illnesses, and even the classical psychoneuroses. Can these well-motivated but not so well-adjusted individuals make good teachers after graduation? Are some of the motivations which we considered less favorable actually incompatible with successful professional work? We believe that a follow-up study of these students with an evaluation of their performance as teachers could help us find some answers to these questions.

CONCLUSION

Two problems as to the functioning of the university psychiatrist arose during this project. The first dealt with whether or not a brief evaluation would allow us to bestow upon the graduates not only a diploma but also a psychiatrically tested and approved seal. Such a "seal of approval" to be looked at some two years hence is a fantastic proposition to the modern-day dynamic psychiatrist. We all realize our inability, even when we have a patient under intensive treatment, to predict how he may operate at some time in the future, let alone to foresee the innumerable intervening life situations and experiences which might either compensate or decompensate his emotional function.

The other question which arose was whether or not the university psychiatrist should be utilized by the administration as a screening agent for individuals considered undesirable in the profession. Such a role for the psychiatrist is one which would seriously impair his function as a therapist. In this position, he becomes a depriving agent and exercises undue omnipotence. We are convinced that our present level of knowledge does not permit us to predict accurately whether or not an individual may be a successful teacher. It is vital that the university psychiatrist place himself in the service of the student's welfare and not align himself with other agents who may be attempting to force a decision on the student.

We would like, then, to summarize our impressions of the purposes of the psychiatric interview and the role of the psychiatrist in teacher-training. Being a good teacher, like being a parent, calls for the establishment of a definite framework or emotional climate characterized both by affection and discipline. Without such a framework neither emotional nor intellectual growth can occur to an optimal degree. Lengthy discussions of teaching methods without taking into account the necessity of establishing this basic climate seem to us pointless. We feel therefore that the most important function of the psychiatrist, in this instance, is to increase this awareness; to sensitize the individual to the nature and importance of good emotional function; and to help him identify and modify his own particular problems. Another but less important function because of its relative infrequency is to assist the student to discover a vocation more suited to his basic interests and personality structure, when it becomes apparent that he has chosen a field in which he will be unhappy and unsuccessful.

Aside from our firm belief that the psychiatrist may well participate in a teacher-training program to the benefit of both the individual and the profession, we would like to make one further recommendation. We believe that if a basic course in mental hygiene were made a requirement for prospective teachers and if they were then interviewed by the psychiatrist in the quarter following such a course, greater value could be obtained from the psychiatric interview. Each student would be sensitized for self-examination by virtue of having studied personality growth and development and the minor anxieties aroused by such study could be utilized as a "therapeutic lever" for greater participation. He would also be desensitized toward psychiatry by virtue of his academic contact, and because of his understanding of the universal nature of mental mechanisms could more easily reveal his basic feelings and attitudes without undue alarm.

A MENTAL HEALTH SEMINAR FOR GENERAL HOSPITAL PERSONNEL

A Report

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FOR each of the millions of people whose physical illnesses are treated in American hospitals, there exists to some degree a number of mental and emotional stresses directly related to the experiences of being ill and of being a patient.

This paper reports an attempt to increase the awareness of hospital employees and staffs of the importance of these disturbances, and an attempt through use of adult education techniques to diminish the traumatic effects of hospitalization experience by bringing to the whole staff of a hospital an increased knowledge and understanding of their patients' feelings and of the emotional stresses and strains that the majority of the patients undergo.

The Setting.

The decision to conduct a mental health seminar for general hospital personnel originated in the development of the staff and services at the new Riley County Hospital at Manhattan, Kansas.

Manhattan, basically a rural community of nearly 20,000, located at the confluence of the Blue and Kaw Rivers, is considered one of the livelier and more progressive communities in Kansas. Its taxes are slightly above normal, but the

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citizenry receives excellent returns in a pattern of municipal services that are better than average, in good schools, a community-wide recreational program, and even a zoo. Sparked by local groups and by the college located there, a healthy degree of community organization and cooperation exists. One of the newcomers among the community agencies is the Riley County Association for Mental Health, only six years old but vigorous and active.

There is a small commercial area in the northwest, a larger business section in the southeast, and a few industrial plants on the outskirts, but the major part of this small city is composed of residential sections.

The Kansas State College of Agriculture and Applied Science, the second largest educational institution in the state, is located in Manhattan. Sixty-three hundred students were enrolled in the academic year 1954-55. A small Bible College is also in Manhattan.

Fifteen miles away, a century-old military post, Fort Riley, makes its presence felt. The fort is now a combat training center with a population which fluctuates from 10,000 to 30,000.

The city serves a trade area of considerable size, as is true of most "rurban" centers in the Great Plains area. Its nearest neighbor of comparable size is Junction City, 18 miles away. Manhattan supplies medical and hospital services to its surrounding trade area. During the last decade it has outgrown its hospital facilities, so that the new hospital became a necessity.

There is no particular flow of patients to the new county hospital from the others in nearby towns, but the staffs of all the hospitals in the area are reasonably well acquainted with each other and accustomed to getting together from time to time to work out common problems. The other hospitals in the area are generally small, local facilities of 50 or fewer beds.

The combination of the newly-opened hospital, an active local Mental Health Association, and a loose network of hospital cooperation formed the background for the attempt in mental health education.

Development of the Seminar Plan.

The administrator of the new hospital was faced with the problem of integrating a brand new group of hospital workers recruited from the residents of the community, wives of students at the college, and the dependents of military personnel—a staff characterized by high turnover and widely diversified experience. One common factor was this staff's generally inadequate mental hygiene orientation. It appeared to the administrator that two birds might be killed with one stone, and he requested help from the county Mental Health Association.

The board of the Riley County Association for Mental Health thought the request was pertinent and appointed a committee to consider the matter and report back. The committee consisted of the hospital administrator, a school health nurse, and the college's coordinator of nursing education. The committee's report stated:

(1) All hospital patients have feelings connected with their illness and hospitalization.

(2) Their feelings vary according to their personalities and the reasons for hospitalization.

(3) These feelings affect their response to medical care.

(4) The hospital experience has a high potential for being traumatic.

(5) All hospital workers in contact with the patient affect his emotional environment and his interpretation of the hospital experience.

These views, coupled with the fact that there had previously been little concern with the mental hygiene aspects of hospital care, made the committee feel that there would be much value in an educational program in mental hygiene designed to reach all hospital personnel, both professional and non-professional.

These findings were reported back to the board of the Mental Health Association, and were approved. The association thereafter gave strong moral support, and financial assistance within its means.

The committee next invited the Office of General Extension of Kansas State College to join in the project.

Since this department exists to make the resources of the

college available to groups outside the academic walls, it considered the project to be well within its functions—and one which was not pre-packaged, needing only mechanical supervision, but a project which would make good use of the college's skills in planning and executing a program of adult education. The department accepted promptly, agreeing to accept major responsibility for the venture under the general supervision of what might be called a planning committee.

This committee consisted of the original Mental Health Association committee and members of the college's general extension department plus a considerable number of individuals invited in from time to time for advice on particular problems. This last group included members of the staff of the mental hygiene division of the State Board of Health, a school health nurse, members of interested college departments, a physician, and the chairman of the local nurses' association.

The state health department was invited to provide program material, and promptly accepted. Since various divisions of the department are extensively concerned with hospitals, hospital services, mental hygiene, and community organization for preventive mental health services, the plan appeared an effective and economical use of its personnel in the development of a local health program.

Early committee discussions resulted in general plans that were followed quite closely thereafter. A general topic—"Mental States of the Physically Ill"—was agreed upon. It was decided to divide this large topic into a number of smaller ones, according to the kinds of general medical services—hospital administration, obstetrical, surgical, medical services, etc. Thus came into being a general outline of a seven-session seminar series, to be financed partly by the local Mental Health Association and partly by a modest fee.

Several meeting plans were proposed, including the holding of separate meetings for professional and non-professional personnel. It was eventually decided to have all personnel attend the same sessions. Because whole-day sessions of afternoon and evening sessions would make it impossible for on-duty personnel to attend, it was decided to hold one evening session each week.

Technical and mechanical details became the responsibility of the college's Office of General Extension, and they were numerous. The seminar format and the technical level of the presentations had to be considered in view of the heterogeneity of the group. It was eventually decided to have an initial speaker for each session, to introduce the evening's topic with a lecture or film, and to devote the second half of each meeting to small-group discussions and problem-solving, with not more than eight participants seated around small tables.

Interviews were held with the administrators of the hospitals in the area, to determine as nearly as possible what subjects would have the greatest interest and value for the participants. After several discussions, the following topics were arrived at:

- (1) The role of administration.
- (2) The obstetrical patient.
- (3) The pediatric patient.
- (4) The medical patient.
- (5) The surgical patient.
- (6) The chronically ill and aged patient.
- (7) The "good" patient: a summary and review.

The planning committee undertook to find well-qualified people to present these topics.

Invitations were extended to hospital personnel in a seven-county area: administrators, physicians, nurses, aides, student nurses, dietitians, housekeepers, kitchen employees, maintenance, and auxiliary workers were included. Hospital administrators were given the responsibility for recruiting their own personnel, which they did ably. Publicity was by personal contact, mail, radio, and press releases.

Final plans called for meetings to be held on seven consecutive weeks, between 7 and 9:30 p. m., on the Kansas State College campus. The college was chosen instead of Manhattan's county hospital, for at least two reasons. As a general rule, educational programs benefit by the aura of learning which surrounds educational institutions.

The Meetings.

The seven presentations and discussions are briefly summarized in the following paragraphs. The techniques of presentation varied, as previously mentioned. There were

lectures, panel discussions, and films. The manner of presentation varied with the individual speakers.

Summary of the Seminar Sessions

Section 1—Administration

Recognizing that any innovation in the patient-hospital personnel relationship depends upon administrative tolerance, the first session was planned to present the administrator's point of view and overall responsibility for the patients' well-being.

The administrator works under two major pressures: (1) the responsibility of providing the best in hospital and medical care, and (2) the responsibility of operating the hospital plant in the most economical and efficient way possible. To do this, he must employ supervisory personnel who can maintain hospital services with a minimum of friction among staff members. His supervisory staff is charged with employment and direction of capable and efficient staff members in the operation of hospital services.

The medical staff determines the care and treatment needed for each patient. Since the most economical treatments may not be the most effective for the patient, the administrator frequently is confronted with complex problems. His job is to create a balance between what is best for the patient and what it is possible to do within the limits of his budget and the capabilities of his staff, and at the same time to ease as much staff frustration as possible.

In a small community, the hospital administrator needs to be aware that "everybody knows everybody else," and must make special efforts to protect the privacy of his patients.

Session 2—Obstetrics

The emotional problems during pregnancy are many and varied. Hospital staff members need to understand and accept the negative as well as the positive feelings of the woman who comes to the hospital for delivery. They need to recognize that the patient has probably experienced the gamut of emotions from happy anticipation to fear of physical pain. They need to know some of the methods of recognizing unexpressed feelings and how to deal with them. They need to know the

extreme importance of the mother-child relationship from the first contact with the hospital until the patient leaves the hospital.

To stimulate thought and discussion of these factors, a film titled "A Concept of Neonatal Care" was shown to demonstrate a plan of rooming-in.

Subsequent discussion brought out a variety of opinions and emotions on the part of members of the group who were mothers themselves. Members of the medical staff present were divided in opinion, and divergent viewpoints made for a lively discussion period. Many seemingly minor points were emphasized to show the need to be aware of the little thoughtful services that make for the patient's mental comfort as well as for her physical care. At the same time, an understanding of the patient's feelings makes easier the task of the staff in accepting what otherwise might seem unreasonable behavior.

Session 3—Hospital Care of the Young Child

The importance of the mother-child relationship was stressed and demonstrated. The hospital staff must be aware of the emotional needs and fears of the young child who comes for treatment. They must understand the basic fear of separation which besets the child and realize the importance of maintaining the mother-child relationship. They must be prepared not only to tolerate but also encourage the "intrusion" of the mother into the hospital routine whenever possible.

Supervisory staff can do much to handle the reactions of nurses-aides and other staff to child-patients by giving them some understanding of the primary emotional as well as physical needs of the child.

Whenever possible it is best for the young child to have a fixed focus of care in relation to a single person when he must be separated from his mother. Normal babies on occasion can go into depression-like shock and suffer severe emotional trauma as a result of the multiple problems of illness and forced separation.

Discussion following the showing of the film, "The Two-Year-Old Goes to the Hospital," brought out a recognition of the various emotions resulting from hospitalization: anger, fear, withdrawal, insecurity, need for protection, etc. At the

same time, group members recognized that the child may consider hospitalization as a form of punishment. Hostile aggressive behavior may be the expression of a lonely, angry, and frightened child. Understanding these emotions and reactions breeds patience and tolerance on the part of hospital staff.

Session 4—General Medicine

Discussion of the emotional problems of the patient hospitalized for medical care was focused on the feelings of a patient, the head of a family, referred for treatment of a heart condition.

The presentation covered the medical aspect of such a case, the feelings of the patient, the fears of the various family members, and the reality factors of family reorganization as a result of prolonged disruption. Many questions come to the patient's mind; fears become to him reality. It is helpful to let him express these feelings to staff members who understand why they arise. The doctor can determine and personalize factual information. Appropriate staff members can deal with the anxiety of family members who are threatened with the loss of support as well as with the loss of a loved family member.

In the discussion, suggestions for helping the patient deal with his anxiety ranged from a statement of the importance of the attitude of the receptionist who must obtain background information, to the need for a general air of confidence and optimism on the part of the hospital staff, to the place of the chaplain and religion in the hospital.

Differences in dealing with the chronic case as opposed to the acute case brought out the feelings of staff members in working with varying degrees of illness. It was emphasized that the attitude of hospital personnel is basically important in the recovery or decline of a patient.

Session 5—Surgery

The importance of body image and personality figured largely in the presentation and discussion of the feelings of the patient referred for surgery. Surgery is often viewed by the patient as mutilation of his body and potentially damaging to his self-respect.

Some of his fears arising in part from misinformation are fear of infection, fear of deformity, fear of pain, likening anesthesia to death. The surgeon becomes the "father figure" to the patient who has a strong need to be dependent. The surgeon can reassure the patient by giving him enough information to relieve his anxiety and by emphasizing the competence of the staff.

The patient can be relieved of his sense of loss—not so much by words as by the attitude and manner in which they are imparted. Yet too much information—like too little—can add to the patient's anxiety.

Members of the hospital staff must be constantly aware that their personal security or anxieties are surely reflected in the patient's attitude toward himself and his situation.

Session 6—The Psychology of the Chronically Ill

The increase in the population of persons over 65 years of age increases the problems of chronic illness. As the individual grows older, he has less energy and strength. He is probably retired and may feel useless and not needed. He may be partially disabled. He may be the victim of a degenerative disease. Many of his generation view the hospital as a place to die.

As a result, he may retreat into childishness and helplessness. He may retreat into apathy and indifference and "give up." In dealing with these feelings the nurse and other staff members must be ready to stand by him and help make him comfortable by allowing him to express his feelings—even those that are hostile and unreasonable—with a calm acceptance of his right to be heard as an individual. Listening to oft-repeated stories and demands will produce feelings of impatience and rejection in the busy nurse unless she can appreciate that a friendly exchange with the patient can reduce the number of times he will call her for minor care.

Simple practical means of utilizing any remaining strength a patient has can often reduce his anxiety over his fears of complete helplessness. For example, a patient who has suffered a cerebral accident may be able to move only one hand. It gives him a measure of mental relief to "exercise" his fingers

on a soft ball. He can be given the feeling that he is actually doing something to assist in his recovery.

Giving emotional support to a patient during his terminal illness requires emotional stability on the part of staff members. To remain calm and sympathetic rather than cold and indifferent to the end of what to the staff is inevitable and commonplace means an added strain on the staff members in attendance.

Session 7—Summary and Review

The summary and review began with a discussion of several questions: (1) What is the nature of illness? (2) What does it mean to be sick? (3) What does it mean to be in a hospital? (4) What produces a feeling of dis-ease? (Disease means dis-ease.)

Illness is the result of both inner and outer stresses. The equilibrium of mind and body processes is upset when a person cannot meet a condition or situation which causes stress. A person may become sick because of a physical, social, or psychological stress. He is most vulnerable when he is emotionally upset. Being sick is a way of adapting to stress. It is a way of solving problems. (It is the job of the physician and hospital staff to find some solution to the stresses which cause the dis-ease.)

In our society a man is required to be independent while a woman may acceptably be dependent. And so when a man gets sick, he is liable to become very sick because then he can be dependent. The same cultural bias may account for much of the chronic illness among women. Illness can be a way out of trouble and for this reason may be retained longer than necessary. In lower income groups, illness is a financial burden, so such patients tend to recover more rapidly.

One of the major problems in recovery is how to teach the patient not to be a patient when he is ready to recover. When he comes into the hospital, he is taught new routines. He gives up his independence. He must adjust to several important personalities: the doctor, the nurse, the aide—each with his own point of view and personality. He has taken on a sort of separate social role. He has learned to be a *patient*, giving up his normal role in his family, and separating from

it. We must all remember that separation such as this is the most devastating of all human anxieties. It may become so great that the patient becomes even sicker. It is the responsibility of the hospital staff to ameliorate this anxiety and start the patient back on the road to health.

Evaluation.

Considerable emphasis is being placed these days on the evaluation of mental hygiene projects, so that mental health may be pursued in an economical and effective manner. This project was evaluated in several different ways: (1) by a questionnaire which was answered by a significant percentage of the participants, (2) by critical letters submitted by various hospital administrators at the conclusion of the course, and (3) by the more or less experienced group leaders who directed it. While all three of these methods do not add up to a strictly scientific or an entirely satisfactory appraisal of what was actually accomplished, they do give a basis for estimating that accomplishment.

The questionnaire consisted of seven simply phrased questions which the participants answered in their own words. The questions dealt with these things: What session was most useful, and why? What session was least useful, and why? Was the participant interested in enrolling in a second, similar, seminar series? What suggestions could the participant offer for improving the program? And, if a second seminar series was offered, who should be invited to attend, and how should it be scheduled?

The results of the questionnaire are presented in Table 1. Insofar as the small number (48) of completed questionnaires permits the drawing of valid conclusions, the answers suggest (1) that hospital personnel are particularly interested in the emotional implications of hospital care for children and surgical patients, (2) that the participants were satisfied with the general tenor of the course and would welcome another, and (3) that the constitution of the group, and the scheduling of the program, appeared to the participants to be just about right. The relatively unfavorable response to the sixth session, on the chronically ill, was influenced by a number of variables to the point that it defied interpretation—although it

TABLE 1. A PERCENTAGE TABULATION OF RESPONSES TO EVALUATIVE QUERIES RE A SEMINAR IN MENTAL HEALTH EDUCATION

Item	Sessions on					Comparative Evaluation		
	Administration	Obstetrics	Pediatrics	Medicine	Surgery	Aged	Review	
Attendance	80.5%	84.7%	76.3%	97.2%	47.2%	54.1%	63.8%	
Most useful session.	15.7	19.3	20.2	15.7	10.5	4.4	14.2	
Least useful session.	23.0	19.7	1.6	24.6	1.6	21.3	8.2	
Midpoint								
End								
Participant wishes to re-enroll.....	87.5%	10.4%	2.1%	96.0%	4.0%	0.0%	In Doubt	
Participant wishes larger geographical representation	80.4	14.8	4.8	76.0	20.0	4.0		
Participant wishes full-time 1 or 2 day session.....	23.9	73.9	2.2	53.8	46.2	0.0		

NOTE: Attendance percentages are based on a total paid and unpaid registration of 72. If added across, all others total 100.

raises the possibility that hospital workers are refractory to thinking very deeply about the emotional problems of old age and chronic illness.

The letters from the hospital administrators were variously enthusiastic and critical. One, a physician, thought that the factual data was exactly what his staff needed and that the group discussions had given them a valuable opportunity to formulate and express opinions. He requested a continuation of the project during the coming year and said he would recommend it strongly to others. Another believed that she could notice a changed attitude on the part of her workers to patients in general. "At intervals now," she said, "I can see someone change the wording of a remark or eliminate it entirely . . . all were made to feel the importance of the patient." Most criticisms were directed at particular presentations rather than at the overall effect of the series. There was a strong minority feeling that there should have been somewhat more emphasis on practical techniques to aid the employee in his or her direct care of the patient.

The more or less experienced group leaders in charge of the project felt that it had scored a considerable success and that if repeated it could be improved in several quite definite ways.

In view of the number and diversity of the faculty and the extreme heterogeneity of the participants, it seems particularly necessary in the future to provide for one qualified person who would attend and actively participate in all of the sessions, to provide continuity from week to week. It was felt that this person could function well as the permanent chairman of the discussion portion of the program and that he would be the logical person to present the final review and summary.

The group leaders also thought that the discussion sessions could have made more of a contribution than they did. The weaknesses noted were particularly related to the background and experience of the evening's speaker, who undertook to guide the small groups that were set up after the initial presentation of the subject. When the speaker was used to this sort of procedure and comfortable with it, the discussions were usually stimulating and effective; when he was not, they were much less effective. Another weakness was the lack of time;

usually no more than an hour could be allocated for establishment of the small groups, outline of topics, discussion, and summaries. It might have been a better pattern to set aside whole evenings for discussion, giving the small groups time to work through their own thinking on the subjects and thereby come to a more adequate understanding. There was general agreement that the large, bare college classrooms that were used lacked an intimacy and informality that the course really required.

A final note on effectiveness was furnished by information that filtered back to the program committee by one means or another. A nurse's aide was pleased to find that relationships with her patients improved when she could remember their names and so greet them. A receptionist could see that the families of patients were less anxious, and therefore less contrary, when the front desk treated them with more consideration and understanding. Plans for the remodeling of a hospital were made to provide for rooming-in of mothers and babies. Without doubt, results of this sort will continue to pile up as the months go by, to constitute in the end the most effective evaluation that can be made of the program.

While mental hygiene remains an inexact science, replete with observations and conclusions that cannot be strictly repeated or verified, it is only possible to say that the project here described appears to have met successfully two of its three objectives: to make hospital workers aware of the importance of patients' feelings and of their own importance in modifying those feelings in a favorable way. The third objective, creating an awareness of the most effective methods to favorably influence patients' feelings, seemed to have been met only partially.

ESTIMATING SOCIAL INCOMPETENCE IN ADULTS

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THE federal law providing for grants-in-aid to the permanently and totally disabled between 18 and 65 years of age which came into effect in 1950 presented certain problems of selection for State and County Departments of Public Welfare. Disability could be roughly classified into three kinds: bodily or physical handicap, mental disorder, and mental defect. Degrees of physical handicap resulting from deformity, defect, accident, or disease have already been classified by members of the medical and legal professions for purposes of insurance and compensation. Degrees of mental disorder have similarly been classified by psychiatrists for purposes of institutional care and treatment. But the question as to how much mental defect may be considered as permanently and totally disabling has not been definitely answered and presents problems that vary with local conditions.

The results of psychological tests of general mental ability, intelligence tests, have aided in the selection of children and adults for placement in institutions for the feeble-minded. Three categories of mental defect were suggested by Lewis Terman on the basis of mental age or I.Q. obtained on the Stanford-Binet Scales of Intelligence. An additional category of borderline deficiency was suggested for adults having a mental age of about 12 years and an I.Q. near 70.

Classifications of mentally deficient and borderline levels of mental ability have been made by authors of other tests. These vary slightly according to the manner in which the I.Q. is determined from the test scores and the representativeness of the sample of population on which the tests were standardized. Tables 1 and 2 show classifications made by Terman, Kuhlmann, and Wechsler from results on their respective tests. The categories were determined statistically and comprised the lowest two or three percent of the population on tested intelligence.

TABLE 1. LEVELS OF MENTAL DEFICIENCY OF ADULTS ON THE STANFORD-BINET INTELLIGENCE SCALE

<i>M.A.</i>	<i>I.Q.</i>	<i>Classification</i>
0- 3 years.....	0-25	Idiot level
3- 7 years.....	25-50	Imbecile level
7-11 years.....	50-70	Moron level
{ 7- 8 years.....	50-55	{ Low moron level
{ 8-10 years.....	55-65	{ Middle moron level
{ 10-11 years.....	65-70	{ High moron level
11-12 years.....	70-75	Borderline level

It might be considered a simple matter to select a cut-off line of I.Q. level, below which individuals would be considered permanently and totally disabled on the ground of mental deficiency. There could, for instance, be no doubt as to the total and permanent handicap of idiots and imbeciles. But the moron at the upper level of feeble-mindedness may or may not be totally disabled according to the demands of the environment, his physical constitution, emotional stability, and lifelong training.

This problem came to the attention of the writer in her capacity as senior psychologist in the North Carolina State Department of Public Welfare in 1950-51. Intelligence tests were found to be inadequate for determining the degree of mental and social handicap of the middle- and high-grade feeble-minded individuals. Some morons living in rural communities were able to earn their own living and to raise and maintain a family. Others of the same intellectual level were practically incapable of supporting themselves and were dependent on others for the necessities of life.

It was thought that possibly the Vineland Social Maturity Scale might help to differentiate the competent from the incompetent feeble-minded adults. But since this scale was devised originally for use with children, many of the items,

TABLE 2. LEVELS OF MENTAL DEFICIENCY OF ADULTS ON THE KUHLMANN AND THE WECHSLER-BELLEVUE INTELLIGENCE SCALES

<i>Kuhlmann-Binet Scale</i>		<i>Wechsler-Bellevue Scale</i>	
<i>I.Q.</i>	<i>Classification</i>	<i>I.Q.</i>	<i>Classification</i>
below 75	Mentally defective	below 65	Mentally defective
75-84	Borderline	66-79	Borderline

especially at the level of greatest incompetence, were not appropriate for adults. In the absence, then, of a suitable rating scale of social competence for adults of limited mental ability, the writer devised a checklist or inventory of behavior for this purpose. This inventory is described in the following paragraphs and appended in full at the end of this article. Comparison between intelligence test scores and social competence scores are given for a small sample of cases, and suggestions are made as to how the inventory can be of use in social casework.

The Social Competence Inventory for Adults is essentially a standardized interview. Its validity for any individual will depend upon the truthfulness of the informer and the representativeness of the behavior reported. A skilled interviewer would be able to judge fairly well whether the information given by the relative, friend, employer, or guardian of the person to be rated is reliable and valid or not. This would depend, for example, upon how long and how well the informant had known the individual and under what circumstances. Also, it would depend upon the degree of intelligence of the informant himself.

The inventory was intended strictly for the use of professional people trained in the art of interviewing and familiar with the technique of rating, such as psychologists, social workers, and medical practitioners. The usefulness of any rating scale or checklist for assessing behavior is determined to a large extent by the judgment and ability of the rater. Without such ability, scores on a rating scale are meaningless and may be seriously misleading for the person being rated.

The items on the Social Competence Inventory consist of descriptive statements of behavior or habits of action which may be characteristic of a particular adult. Only those items have been included which are essential to some aspect of social competence and self-maintenance. Many of them were selected from case records of persons who had proved incapable of taking care of themselves. The items are arranged in four groups to help classify the nature of the individual's disability, whether that of bodily control, sensory or memory defect, care of self, or emotional control. In each of the four sections

the items are arranged roughly so that the least competent behavior is mentioned at the top of the list and the most competent at the bottom of the list.

The scoring system used is a simple point scale system. Thus, if the scale is to be an accurate measure, some information should be obtained and a score of one or nothing given for every item. It was realized at the outset that this would be an unrealistic ideal. Raters are urged, therefore, to score as many items as possible on the basis of positive information but to place a question mark against those about which they have no information or they are in doubt.

A rating scale of this kind could never be considered an exact measuring device. It is merely a means of general classification. Thus, if two or three items are omitted through lack of information, the broad classification of the person would not be affected. A margin or maximum of five questionable items (marked ?) has been arbitrarily chosen as permissible. No reliance should be placed upon total scores if there are more than five queried items. But the scores on particular items or sections of the inventory may have useful qualitative significance for the caseworker or psychologist, whether the total scores are valid or not.

The broad classification of total scores in degrees of social competence was arbitrarily chosen on the basis of case histories of more than twenty adults who had a long record of incompetence in employment and in self and home maintenance and whose intelligence level was known. This scoring system was regarded as only temporary, but continued use of the scale in the North Carolina State Department of Public Welfare over a period of four years has shown the categories to be valid and useful. The form used in 1951 and 1952 contained 70 items. Several of these were eliminated and others changed in making the final form of 55 items used from 1952 to 1955.

A comparison is given in Table 3 of Social Competence Inventory Scores (final form) and I.Q. on the Stanford-Binet Intelligence Scale, Form L, for persons who were not able to care adequately for themselves and were applying for a grant-in-aid for the permanently and totally disabled between 1952 and 1955. Those persons whose social competence scores

TABLE 3. COMPARISON OF STANFORD-BINET I.Q. AND SOCIAL COMPETENCE SCORES FOR APPLICANTS FOR AID TO THE PERMANENTLY AND TOTALLY DISABLED *

	<i>White Female</i>	<i>Negro Female</i>	<i>White Male</i>	<i>Negro Male</i>
Number of cases	27	9	21	12
Average age	43	40	42	36
Standard deviation	12.1	15.1	13.9	9.2
Average I.Q.	40	34	39	32
(S-B, Form L)				
Standard deviation	10.2	9.4	11.6	7.0
Average Social				
Competence score	26	26	22	22
Standard deviation	8.2	9.4	8.5	10.9
Coefficient of				
correlation .....	.52	.55	.43	.40
(rank difference)				

* These figures are quoted with the kind permission of Commissioner Ellen Winston, North Carolina State Department of Public Welfare.

were available but who had been examined on the Wechsler-Bellevue or other intelligence scales are not included in the table, as I.Q.s obtained on different scales are not comparable, especially at the lower levels of intelligence. It will be noted that there is some positive relationship between social competence scores and intelligence quotients, but not a very close one.

In Table 4 a comparison is made of Social Competence

TABLE 4. COMPARISON OF WECHSLER-BELLEVUE I.Q. AND SOCIAL COMPETENCE SCORES FOR CASES REFERRED FOR CONSIDERATION BY EUGENICS BOARD *

	<i>White Female</i>	<i>Negro Female</i>	<i>White Male</i>	<i>Negro Male</i>	<i>Negro Male</i>
Number of cases	11	13	1	1	1
			Age	Age	Age
Average age in years	26	27	53	23	30
Standard deviation	7.5	6.7			
Average I.Q.	49	54	Army B	W-B	S-B
(W-B Form I)					
Standard deviation	11.9	5.3	72	34	46
Average Social			Score	Score	Score
Competence score	33	34	42	31	24
Standard deviation	10.3	4.6			
Coefficient of correlation	.50	.92			

* These figures are quoted with the kind permission of Commissioner Ellen Winston, North Carolina State Department of Public Welfare.

Inventory Scores and I.Q.s obtained on the Wechsler-Bellevue Intelligence Scale, Form I, by persons who were being referred to the North Carolina Eugenics Board for consideration for eligibility for sterilization. Since a larger proportion of these cases had been examined on the Wechsler-Bellevue Intelligence Scale than on the Stanford-Binet Scale, the latter were omitted in this table instead of the former. Again, it will be noticed that there is a positive relationship between I.Q. and Social Competence Inventory Scores. The relationship is highly positive for the female Negro cases.

In deciding whether an individual is eligible for a grant-in-aid to the permanently and totally disabled on the grounds of mental deficiency, the question of "permanence" has to be considered as well as the degree of mental and social disability. Some persons who were not mentally deficient as children may become feeble-minded in later life as a result of brain damage or functional deterioration. Some of these individuals are likely to be permanently handicapped but others only temporarily so. Psychologists and psychiatrists have diagnostic tests which, used along with intelligence tests, help to determine the "permanence" or temporary nature of the mental defect. Scores on particular items and sections of the Social Competence Inventory, especially when obtained at repeated intervals, may also aid in the diagnosis of the nature of the mental handicap.

The Social Competence Inventory has been found to be of assistance to the staff members of the North Carolina State Department of Public Welfare in determining suitability for A.P.T.D. grants. It has also been found helpful to members of the Eugenics Board in determining eligibility for sterilization. Total Social Competence scores and scores on the separate sections, when taken in conjunction with intelligence test results and personal history, have helped particularly in making decisions on borderline cases.

The inventory has also been of use in connection with welfare services for old people. When it has been necessary to arrange boarding-home placement for aged men or women, scores on the Social Competence Inventory have helped workers decide upon the type of care that these people needed. Some would need close supervision and care for personal

hygiene while others, though unable to earn a living for themselves, could be trusted to keep themselves clean and go about unaided.

SUMMARY

A standardized interview and behavior checklist for the use of professional workers in determining the social competence of adults of inferior mental ability has been briefly described. Although it yields numerical scores, it cannot be considered an exact measuring device. The scores have value only as a means of broad classification for practical purposes when the inventory is used by skilled interviewers and observers. It has been found to be helpful in determining eligibility of clients for aid to the permanently and totally disabled and also useful to one Eugenics Board, when considering requests for sterilization.

APPENDIX

Social Competence Inventory for Adults

Explanation and Directions

This checklist of behavior of adults is intended for the use of psychologists, medical practitioners, and social workers to aid them in estimating the social competence of handicapped, mentally retarded, or senile persons. It should be helpful in making decisions with regard to the eligibility of adults between 18 and 65 years of age who are applying for public assistance benefits under the law for grants-in-aid for the permanently and totally disabled. Social workers will find it especially useful when making plans for the care of the aged or when preparing records of cases for consideration by the Eugenics Board for sterilization.

The inventory is to be checked from direct observation and from information supplied by relatives, friends, or guardians who are well acquainted with persons under consideration and whose testimony is reliable. Care must be taken to see that ratings are not made on false evidence, whether this be given unintentionally or prompted by some definite motive. When falsification of information is suspected the inventory ratings should be discarded.

Scoring

Mark (1) and score one point for each statement which applies to the person under consideration. Mark (0) against each statement that is not true for the person and mark (?) when in doubt. If more than five items are marked (?), the total score cannot be used as an index of social competence.

The maximum score is 55. An individual who scores 50 or over has adequate social competence for normal community living. He or she is capable of social independence and self-maintenance.

A score between 40 and 50 signifies fairly adequate social competence. A person who scores within this range would be able to get along outside an institution, and probably could contribute in some measure to his or her own maintenance.

One whose score falls between 30 and 40 is partially disabled and somewhat inadequate in social competence. He or she would find self-maintenance and group competition very difficult. Some supervision would be needed.

An individual who scores between 15 and 30 has inadequate social competence for independent living. He or she would require considerable care and supervision and would be able to contribute very little to his or her own care and maintenance.

Feeble-minded or physically handicapped persons who score less than 30 may be considered to be permanently and totally disabled.

Scores below 15 indicate social incompetence to the extent that full care is necessary, in a public institution, hospital, or private home.

Individuals who score below 15 on the inventory may be considered to be permanently and totally disabled.

This scoring system is tentative, pending standardization on a sample cross-section of the population. It is based partly on the mental-age equivalents of the behavior items on the Stanford-Binet Intelligence Scales, social-age equivalents on the Vineland Social Maturity Scale, and upon clinical observation and experience. Low-grade and middle-grade feeble-minded persons may be considered to be permanently and totally disabled, but some high-grade feeble-minded persons are only partially disabled. They may have practical abilities

and social competence considerably above the level of their intellectual capacities.

On the other hand, there are high-grade mentally deficient persons who are so socially incompetent or emotionally unstable as to be incapable of earning a living. The Social Competence Inventory should be of assistance in determining whether these borderline cases may or may not be considered to be eligible for a grant-in-aid of the permanently and totally disabled.

Name..... Birthdate..... Date.....
 Case number..... Age..... Total score.....
 Informant..... Recorder.....

I. Motor Skills and Control

The person can:

Score

- 1. Stand without support for ten or more minutes.
- 2. Walk a mile or more unattended.
- 3. Write own name legibly.
- 4. Copy a verse of "America" or write a half-page letter legibly.
- 5. Do simple manual work at home such as digging, chopping wood, darning, sweeping, dusting.
- 6. Do simple manual work for remuneration, such as fruit and cotton picking, car washing.
- 7. Do semi-skilled work, such as truck or tractor driving, lathe turning, wood sawing, housecleaning, laundry work.
- 8. Work efficiently at a skilled occupation, such as shoe mending, store-keeping, cooking, house painting.
- 9. Drive an automobile, motorcycle, or bus.
- 10. Do precise finger work, as in watch repairing, drafting, hair dressing, needlecraft, stenography, engraving, musical instrument playing.

Comments:

II. Perception and Memory

The person can:

Score

- 1. Recognize traffic lights and signals: red; stop; green; go; amber; caution.
- 2. Read road and street signs: no parking, one way, main street, etc.
- 3. Read a newspaper column or other small print with or without glasses.
- 4. Speak intelligibly, pronouncing words of three or more syllables and double consonants correctly.

- 5. Count and add the white spots over six on any two standard-size black dominoes.
- 6. Make change under a dollar; e.g., fourteen cents out of twenty-five, two cents out of a dime.
- 7. Tell the time by clock or watch correctly to the minute.
- 8. Hear and repeat ordinary speech four feet or more away, with or without hearing aid, e.g., repeat "There are fifty-two weeks in a year" heard across an office desk.
- 9. Hear and repeat ordinary speech ten feet or more away without hearing aid, e.g., repeat "Christmas Day is on December twenty-fifth," heard from the end of the room.
- 10. Make telephone calls and take messages by telephone.
- 11. Tell own name and address on request.
- 12. Point correctly to right and left sides of room or road.
- 13. Turn to face north and then east when asked to do so after being shown which is the north side of the room.
- 14. Remember practical instructions, such as shopping lists of five or more articles for several hours, long enough to execute a task assignment.
- 15. Understand simple causality and explain what makes a door close and bang, a bicycle to go, or a cigarette to light.

Comments: .

III. *Self-Care and Self-Help*

The person:

Score

- 1. Washes and bathes self, keeping clean without supervision or assistance.
- 2. Has ordinary bowel and bladder control, does not soil or wet clothing.
- 3. Can dress and undress without help, fastening and unfastening buttons, press-stubs, zip fasteners and shoe laces.
- 4. Can take a shower or sponge bath without assistance.
- 5. Can feed self, using spoon and cup or glass unassisted.
- 6. Uses table utensils dexterously without spilling, e.g., knife, fork, cup, glass.
- 7. Has ordinary control of appetite, eats moderately. Neither eats to excess nor habitually refuses food to the serious detriment of health.
- 8. Has control over drinking intoxicating beverages, does not drink to excess, causing embarrassment to others or reducing work efficiency.
- 9. Can get on and off streetcars and buses without help or much difficulty.
- 10. Can travel independently by any means of public transport: train, street-car, bus, or plane.
- 11. Can be trusted to find own way about familiar neighborhood and return within a given time. Does not wander and lose sense of direction.
- 12. Can be trusted to go about alone in an unfamiliar neighborhood and return; would ask the way and follow directions when necessary.
- 13. Takes care of own clothing and belongings, is not careless or destructive.
- 14. Manages own finances, paying taxes, rent, and other bills.
- 15. Earns a living and maintains self independently, or could do so if work were available.

Comments:

IV. *Social Relationships and Emotional Control*

The person:

Score

- 1. Gets along well with family and friends without undue quarreling or complaining.
- 2. Shows interest in the affairs of others, is not indifferent and withdrawn, inquires after health or others' activities.
- 3. Does helpful things for others, is kind and considerate, shares possessions.
- 4. Takes care of other people's belongings or public property, has not repeatedly damaged, destroyed, or confiscated the property of others.
- 5. Joins in group enterprises; e.g., social entertainment, church affairs, choir singing, discussions.
- 6. Plays table games, adhering to rules, such as checkers, poker, dominoes.
- 7. Plays active games, adhering to rules, such as horseshoes, baseball, square dancing, bowling.
- 8. Takes responsible care of younger persons during the day, catering to physical needs and habit training or giving recreational supervision.
- 9. Assumes responsibility for the night care of children, or could do so to the extent of staying all night alone in the house with them.
- 10. Takes full responsibility for the maintenance and care of a family.
- 11. Has control over sexual behavior, is not a public nuisance because of perverse or other sexual excesses.
- 12. Has control over the use of profane language, does not have outbursts of temper and profanity.
- 13. Has control over emotional moods, does not give way to extreme depression and weeping or to noisy excitement.
- 14. Has control over aggressive impulses, does not hurt or frighten others with violence or threats.
- 15. Has sufficient courage and confidence to converse with strangers or visit new places unattended. Is not excessively timid.

Comments:

PARENT-CHILD COUNSELING IN A MULTIPLE SERVICE AGENCY

SAUL HOFSTEIN, D.S.W.*

IN establishing the Jewish Community Services of Long Island in 1942, its founders aimed at developing a comprehensive program which would include, in addition to the services traditionally carried by family agencies, the child guidance function. Beginning in a new agency, the first professional staff attempted to draw on the then current practice of the family and child guidance agencies. Caseloads were undifferentiated and the staff as a whole worked with cases involving disturbed behavior of children in addition to the more usual situations of family agencies. While much that was helpful derived from the experience of the family and child guidance agencies, somehow that was not enough.

The coexistence of child guidance and family services in one agency introduced certain differences which made for problem. The family agency, which today regards its responsibility for children in the family differently, then worked with family relationships primarily involving adults with the underlying assumption that, even where problem existed in the child, a change in the parents' attitudes would result in a change in the child. Where that did not happen, the family agency referred the child to a child guidance clinic. Implicit in this practice of working through parent alone seemed to be the assumption that the child had no self of his own, that he did not contribute to the problem in relationship or participate in its modification unless he was sick. The child guidance clinic, on the other hand, had as its primary concern the child, and its emphasis was on changing the child. The role of the parents was secondary, if it was admitted at all. Workers in J.C.S.L.I. carrying both marital and child guidance cases experienced confusion in their rôle. What could they offer? Where would their emphasis be? They naturally tended to deal with these cases according to their previous experience, concentrating

* At the time this article was written the author was supervisor of children's and youth services for Jewish Community Services of Long Island. He is now assistant director of the Infants Home of Brooklyn.

either on parent or child, often shifting from one to the other. Neither felt right.

As the agency experienced its dissatisfaction with the resulting service for children, it decided to bring in a part-time consultant to train staff for this specialized function. Rather than undertake to train the entire staff, the decision was made to select two workers with previous experience in children's work, one from the field of child guidance and one with a background in placement. As the consultant and the two workers began, they were at first caught up too in the dilemma and tended to stress the child guidance approach with its emphasis on the child. Gradually, however, a different conception began to emerge. The basic emphasis in service could not be adult *or* child; rather, it had to be the relationship between parent *and* child. This fundamental relationship provided the perspective from which all work with the client—whether parent or child—could be approached.

At first glance, it might be said that this relationship is similarly the primary concern of the child guidance clinic. But there is a difference. An underlying assumption in most child guidance clinics is that the child is sick or at least that his disorder is such as to require treatment by the psychiatrist. Even where the social worker sees the child, psychiatric controls are introduced and the worker with the child is referred to as the "therapist." The implication generally is that the child in difficulty must undergo a fairly extensive modification of personality to be helped. In contrast, in our agency, as the parent-child relationship became the focus of treatment, the assumption was that many children could get caught in relationship problems as well as adults and that they could be helped through casework methods to modify their role in the relationship, as could the adults. This too is different from the family agency emphasis on the parent, and referral to the child guidance clinic where that failed to change the child. Since we saw the parent-child relationship as polar, with child and parent both playing a part in whatever happened therein, we recognized the need for both to work on this in order to bring about basic change.

As we came to the conclusion that dealing with children's problems in such a setting required the development of a set

of attitudes, a basic orientation enabling the worker constantly to keep in mind the parent-child relationship whether he worked with child, parent, or both, the need to separate this function from the others in the agency became apparent. The addition of a supervisor, trained in working with parent-child relationships and the organization of a separate division within the agency was the next step. While parent-child counseling was seen as the core service of this new division, it became apparent too that a similar orientation was necessary in regard to a variety of other services involving children in their own homes. These services included direct financial assistance growing out of a child's need, referral to specialized resources for children, parent counseling either in relation to planning for a child with some special problem not amenable to treatment, or in relation to a parent's problem in carrying the parental rôle. For those children whose problems were more deeply internalized or who showed marked pathology, provision was made for diagnosis and treatment by qualified psychiatrists.¹

Underlying the subsequent development of the Children's and Youth Services have been certain beliefs and assumptions. We have felt that problems related to children had in them a certain common element which could best be dealt with by workers especially trained and developed in the area of parent-child relationships. A further assumption has been that there is sufficient complexity and uniqueness in the kinds of problems presented in relation to children in a community agency to warrant a great degree of concentration, and that such concentration would lead to a fuller awareness of the nature of the problems dealt with as well as the development of more specialized methods of dealing with them. Implicit as well has been the belief that with a specialized division focused on service for children and parents, the agency would be in a better position to determine needs in this area, to learn about specialized resources for children available in the community, and to develop new services where necessary to meet those needs.

The availability within one agency of two distinct divisions—

¹ See Aptekar, Herbert. "The Use of Private Psychiatrists by a Social Agency." *Jewish Social Service Quarterly*, Vol. XXV, No. 10, Feb. 1944.

one in which the primary orientation is upon the adult and his relationships with other adults, the other upon parents' relationship to and responsibility for the child—introduces another factor which is of profound significance for helping. The client must make a conscious choice regarding the perspective from which he wishes to work on his problem. A basic problem in all helping is how to engage the client's will in the helping process. Whatever the diagnostic perspicacity and skill of the counselor, unless the client participates actively in whatever is undertaken to help him, the result will be minimal. The need for the client to decide where he wishes to seek help provides a beginning of such engagement which has significance throughout the counseling experience. It is not the worker who establishes the focus and the goals of treatment; it is the client. This makes possible a counseling process that is focused and can be directed at the central problem for which the client seeks help.

While, as noted above, the Children's and Youth Division offers a variety of services, to illustrate the points made thus far I should like to examine more specifically only one of those services, counseling directed at modification of the parent-child relationship. Despite all that has been written about this relationship, we still have much to learn about it. Involved in it are biological growth processes as well as social and cultural factors. It is not entered into by choice nor can it be severed at will. In addition to mother, father, and child, other siblings, relatives, and the community have their effect on it. The parent-child relationship is also profoundly influenced by the personality of each of the participants and by the relationship between mother and father and other relationships within the family. What happens to the child outside the family also has its influence. Of all relationships, that of parent and child is perhaps the most dynamic. It begins at a point of almost complete symbiosis and must move through many phases to a level where the child may establish an independent existence. It is ever-changing in nature. So complex and dynamic a relationship cannot be dealt with as a totality.

How to encompass so involved a relationship within a time-limited experience and to effect changes in it is a core problem

in the development of counseling skill in this area. Kurt Lewin has shown how complexly inter-related a particular relationship is with surrounding relationships. He has shown too how change need not be in the total complex pattern of what he has described as a psychological, social, environmental field but that change in one part of that has a significant effect upon the total constellation as well as upon its other parts. We have tried to apply this in helping parents and children where there has been disturbance in the parent-child relationship. Underlying our procedures is the belief that both child and parents possess the capacity for growth and that the parent-child relationship inherently is one which makes for growth in the child. The failure of the child to grow normally or the distortion of a normal parent-child relationship results from a blocking of the natural growth potential. In trying to help parents and children overcome whatever it is that blocks them in their relationship, we do not attempt somehow to return to the point where the blocking has occurred. Heraclitus, a long time ago, said, "Into the same river you could not step twice, for other waters are flowing." We believe that whatever this blocking may have been in the past, something is happening in the relationship at the present time which continues to create problem. It is that to which we direct ourselves.

We have tried to meet the problem of effecting change in such an intricate relationship by emphasizing certain basic elements which would permit us to work with parents and child on where the problems lie in their relationship together. Through setting up a structure which involves mother, father, and child, we have, so to speak, established within the agency a simplified replica of the parent-child relationship with which we can work. We have evolved certain procedures and practices which provide definite steps for the participants as they move into a counseling experience and give them an opportunity to bring out the attitudes and feelings which play so important a part in the perpetuation of problem.

The pattern of seeing the family members involved, whether separately or together, whether with one worker seeing both child and parents or having separate workers see them, is related closely to the way in which we deal with the parent-child relationship. The problem, as we have pointed out

above; is somehow to take hold of this relationship so as to bring out the attitudes and feelings of each participant in it. As can be seen, the task of the worker is a most complicated one. From that standpoint alone, separating the case—that is, having one worker work with parents and another with the child—although it introduces administrative problems, does make possible some simplification of the worker's role. Each worker then is enabled to concentrate on one aspect of the relationship. Naturally, close coordination between the two workers must be maintained.

Aside from the more practical considerations, there are basic psychological and casework implications in the practice of dividing parent-child counseling cases. Provision for concurrent though independent interviews for parents and children provides the means of observing and dealing directly in the actual experience of separation with the attitudes and feelings of parents and child towards being apart. One has only to see what happens as mother and child go to their respective offices to grasp the significance of the separation. Throughout the counseling experience too each worker can deal directly with their changing reactions to the separation. As parent and child come together at the end of the counseling experience, the reunion has almost always considerable symbolic significance. Where division of cases has not been administratively possible, we have found that workers have had to struggle with conflicting identifications within themselves. Often too in unseparated cases parent and child compete for the worker, and each may be inhibited in expressing feeling by the awareness that the same worker is seeing the other participant. As a result, our choice has been to have different workers see parent and child where that has been at all possible.

There are certain things that the parents must agree to in starting in parent-child counseling. Both mother and father must agree to come for regular appointments, the mother on a weekly basis and the father to a lesser but equally planned extent. They must be ready to prepare the child for coming to the agency and must agree to pay a fee consistent with their income and resources. Working on these essential questions constitutes the first step in parent-child counseling. We have also found it helpful to establish at the beginning a trial

period which permits workers and parents to test out whether this experience can be helpful. Once mutual agreement is reached to continue beyond the trial period, we have found it helpful for the agency generally to offer a definite number of sessions for parent and child. The entire parent-child counseling process usually requires fifteen to twenty sessions for each participant.

The objective here again is not to effect a total modification in the personality of the child or the parents. Rather, we attempt in this limited counseling experience to help the parents and the child face what factors are blocking them in the normal growth potential of the parent-child relationship and to help them then take steps toward the modification of those factors. Numerous follow-up interviews with clients who have finished a counseling experience have borne out our belief that once we had helped the family to begin to take hold of their problem they could continue to work on it on their own.

The procedures we have worked out too include a pattern for the father's participation. We have seen increasingly how important to the developing relationship between mother and child is the father's rôle. When about eight years ago, we began to insist that the father be part of the treatment, fathers were ready to involve themselves and to carry their share of change in their relationship to the child. Through periodic joint interviews in which mother and father meet together with their worker we stress the mutuality of responsibility for parenthood.

Our basic assumption in direct work with children is that the child has an inherent growth potential which may be blocked in one way or another. We have found accordingly that many children are capable of making use of a counseling experience that does not attempt any complete change of their basic personality. Children with serious emotional disturbance are provided treatment through our panel psychiatrists. As with parents, in our work with children we also have been developing various methods and procedures which provide for the child opportunities for choices and an experience of freedom and acceptance, accompanied at the same time by very real limits with which he will have to come to terms as he does at home and in the community. Naturally,

in such work we must take into account the psychology of childhood. Of importance in developing counseling methods are the facts that children talk a language which is different in many respects from that of adults; that they live more in projection, imagination, and fantasy than do adults; that they have less control of their impulses; and that their responses and way of functioning vary with age. Since casework has had limited experience in working with children, particularly in this type of setting, we have had to learn from practice. We have had to discern first which children could use this casework help and which would have to be referred to our psychiatric panel for treatment. We have had to come to understand the language of children and to develop means of bringing into our sessions with them the focus of our counseling service—that is, the parent-child relationship. It has been important too to recognize, come to terms with, and use the fact that in most cases the child comes, not on his own volition, but under parental compulsion.

Actually some of the problems inherent in working with children have seemed more formidable in contemplation than in practice. I think generally we did not give enough credit to children for what they were truly capable of when offered a consistent, understanding, positive experience based on trust in their own ability to use help. We have found that children were able to deal with the basic reasons for their coming and that they could express their problem and could use the help of the workers in working on it. True, they do not always express themselves in the language that adults do, but in their play and in their reactions—in what they say, for example, on the ediphone, if one happens to be available—and the words they put into other peoples' mouths, in their projections, one can find a language as understandable as that of any adult.

Much can be said about what is involved in the training of caseworkers to work with children. That is not any easy task, but we have found that caseworkers, once they have overcome their stereotyped attitudes about children and have developed an understanding of the basic parent-child relationship and of the processes through which we try to effect changes in it, are capable of learning to deal with and understand children. But our purpose here is not to discuss training.

In our development of parent-child counseling, we have retained a flexibility of approach. Our procedures have been related to a variety of family situations and problems with children. Perhaps the best way to illustrate parent-child counseling as we practice it is to tell you about one such case.

Mr. Lewis² called the agency initially to ask for a woman to sleep in with his child. His wife had died and he was frantic about how he could care for his 3½-year-old son. He accepted an offer to come in even though we could not meet his request. It was obvious in the interview that he was not ready really to face the loss of his wife and was unable to work out any plan which would involve actual facing of that fact. Desperate and in a state of panic initially he could take hold of himself as the worker in the two interviews helped him to examine concrete possibilities and then could recognize that the plan he had contemplated—of having just any domestic worker care for his son—would not meet the needs of his child. From that, he expressed interest in and was referred to a placement agency. At that agency, he could not accept the conditions of placement. He was not heard from further at that time.

Five years later he called the agency to ask for help with Benny, who was then living with an aunt. Benny had no friends, disregarded others, seemed to be battling him all the time, and had trouble in school. In his interview,³ Mr. Lewis found it hard to begin but then could talk of his own unhappiness about his son and his difficulty in reaching him. It was apparent that the boy was responding through behavior to what was happening in relationship to his father and to the absence of his mother. Mr. Lewis moved from one extreme to the other. Either he would give in completely or fly into rages at Benny's behavior. The aunt with whom Ben was staying felt she had to counteract Mr. Lewis' leniency by being overly stern and throwing up at Ben constantly the fact that she was doing so much to care for him.

In many ways this case was certainly not typical of the large majority of situations we see where mother and father are both present in the home and where the child is living in that home. However, as a community agency concerned in

² All identifying material in this case has been modified.

³ The workers in this case were Isidore Shapiro and Mrs. Murial Gladstein.

the welfare of children, we did feel that we had a very real responsibility. Here was a situation where father and son were moving further apart, where the son was developing really serious, anti-social behavior and becoming increasingly unhappy. As we considered this situation we felt we could still use our basic procedures as described above.

Both the father and the aunt were seen and indicated their readiness to work with us on their part in the problem while we worked with Benny. Benny was to be seen by a separate worker. During the initial trial period, Mr. Lewis at first persisted in demanding formulas for "handling his son." What should he do? How could he make Benny conform to his own needs? Denying any quick solution, the worker helped Mr. Lewis examine his own rôle in specific incidents involving Benny. In connection with these, Mr. Lewis came to recognize that his own attitudes had something to do with Ben's behavior. The aunt, on the other hand, expressed considerable antagonism towards Benny and later could talk of her feeling of being imposed upon by Mr. Lewis. As the worker related to her hostility, the aunt could get to the other side too and talk of her love for Benny, who came to her after she had seen her own children grow up. Particularly as they saw how Benny could get started with his worker, both Mr. Lewis and the aunt decided at the end of the trial period that they wanted to continue.

Benny in starting with his worker, tended to deny the existence of any problem; he was aware that he was coming because of the various troubles he was having but denied any unhappiness. He was very conforming and careful. By his third interview, he talked of his "troubles," began acting aggressively, and said that he would want to continue to try to make things better. He brought out too his conflict about his father's pending remarriage.

In all, Benny was seen 16 times, Mr. Lewis 12 times and the aunt 19 times. While initially Mr. Lewis tended to stress Benny's behavior, by his seventh interview he could, with the workers help look more at his own attitudes towards Ben. He saw that he was putting excessive demands upon Ben while at the same time not really trusting him. Slowly he came to the realization that he could not make everything good for Ben.

For instance, he had never told his son that his mother had died. He had also not involved Benny fully in his plans to remarry. Only in the middle of his contacts was he really ready to face the fact that he feared his son essentially was showing characteristics inherited from his mother and his basic concern about that. As he could begin to come to a better understanding of his son and allow his own positive feelings to come out, he found much that was good in Ben that he could trust and plan for. At the same time, he was able to take over more of the discipline of Ben.

The aunt at first put all the fault on Benny and his father. As the worker related to her feeling, she could begin to think more of her own rôle. As she saw the worker helping Mr. Lewis to take more responsibility, she could bring out more directly what it meant to her to take on a child at her age and to begin to face too some of the distrust she had of this child. She related this to her own early life experience as an orphan. Gradually she too found more that she could trust in Benny. As she reacted to Ben's growing relationship with his worker, the aunt brought in another side of her feeling, her need to keep Benny close to her. As the worker related this to Mr. Lewis's forthcoming marriage, the aunt could face her own divided feelings and bring out her fear of losing Benny. She could use the worker's help in facing what giving up Benny to his new mother would mean. As Benny himself showed more feeling for her, and as she sensed that this love would continue even after he left, she felt ready for the separation. She found a job which she would start when Benny left. The fiancée of the father came to see the worker on her own volition during the ending phase. She used her interview to gain more confidence about taking up responsibility as Benny's new mother but could also bring out all her fear of that.

Benny, after the trial period, could not talk of his troubles at first. He acted out his problem by shouting and struggling against the limits in his hours. As the worker, while holding him to the "rules," could nonetheless accept his behavior and relate it to what was happening outside, Benny spoke of his longing for his mother and his mixed feelings about his father's fiancée. The worker's acceptance of that feeling and helping him come to terms with his loss made possible Benny's talking

of his problem of "how to act with ladies" and his confusion about where he belonged. The worker could relate this to what Benny was doing with her. Was that too part of his trouble at school and with his aunt and father? Through the worker's consistent use of the natural limits of her hours with him, Benny was able to develop a greater readiness to relate himself to those limits and to move into a different kind of relationship with an adult figure, which he then could carry over to his aunt, his father, and his father's fiancée. At first there was a good deal of hostility and jealousy at the idea that someone else would be sharing his father. Gradually, however, he began to develop a positive relationship to the fiancée. In his last interview he told the worker how he planned to throw out some of his toys to make room for his new mother. In ending, he asked the worker to help him write a note: "Benny is growing up and will soon be 9." Mr. Lewis called about a month after the final interview to tell the worker he felt Benny was wonderful, though he acts up sometimes. He saw this occasional acting up as natural. He felt quite ready to take care of things and credited the agency with "bringing his family together."

Perhaps we can end on the note of this father. Our task as we conceive it in the Children's and Youth Services is to help parents make possible the fullest growth of children and to help children directly to realize their growth potential. Our trust is in the ability of children and parents really to meet the problems they must face together, once they have had help in freeing themselves from whatever blocks their natural capacities. Our conviction is that casework can develop methods and services which will make such constructive growth possible. There are many problems inherent in such help with parents and children. I have tried here to discuss a few of them. We cannot function on the assumption that we know everything that is necessary to help parents and children. Knowledge is an ever-widening spiral. As we learn, we find new areas for further study. As a division concerned with helping parents and children live together and fulfill their rôle in society, we are eager to expand our own knowledge, to test out again and again our own and other ways of working, to face the problems inherent in this field, and to develop ever-improving services for children in our community.

COHORT STUDIES OF MENTAL DISEASE IN NEW YORK STATE, 1943 TO 1949*

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PART I

IT was accepted as a fact, for many years, that the average duration of residence in a mental hospital was about five and a half years. It appears, upon examination, that this figure probably was obtained by averaging the total duration of residence, excluding time in convalescent care, of patients who died in state hospitals for mental disease. Obviously, this procedure could not be correct, for it did not include the corresponding data for patients who did not die but were discharged back to the community. There was an apparent implication that the duration of residence was the same, whether patients left the hospitals by death or by discharge. But even if both were included in the average duration of residence, there would still be a fallacy in the reasoning because it excludes those patients who were in the hospitals at the end of specified periods. In a closed system, in which patients must all ultimately be discharged or die, the average duration of residence could be obtained by a consideration of these two groups. In an actual system of mental hospitals, such a procedure is not possible. The population that remains in the hospitals must always be considered. Therefore, another procedure must be adopted in order to determine the distribution of periods of hospital residence. Instead of beginning with a population made up of discharges and deaths, we must reverse the order of observation and begin with a group of hospital admissions within a specified period, the members of which must all be observed subsequently for equal durations of time. Within each of these intervals, there is recorded the number of patients who leave, die, or remain at the end of the interval.

* This is the first of a series of eight or nine reports based on an investigation supported by a research grant from the National Institute of Mental Health, of the National Institutes of Health, United States Public Health Service.

Such a population is called a cohort, and by following the history of each member of the cohort it is possible to obtain data from which one may derive correct rates of discharge, of mortality, and of average duration of residence in mental hospitals.

The preparation of such cohorts was made possible for the New York civil state hospitals through the introduction April 1, 1943 of a system of statistical recording on punched cards. These cards were prepared for every patient admitted to a mental hospital after that date, and a corresponding card was prepared when the patient was discharged or died. If the patient was readmitted, the process was repeated, and all the punched cards for each patient were brought together and filed chronologically.

At the beginning of this investigation, the statistical files included punched cards for all first admissions, discharges, and deaths from April 1, 1943 through March 31, 1949. First admissions during the fiscal year which began April 1, 1943 and ended March 31, 1944 were thus followed from the date of admission to March 31, 1949. The maximum period during this interval was six years; patients admitted at the end of this fiscal year could be followed for only five years. Because it is necessary that each member of the cohort have the same period of exposure, none could be followed for a period greater than the minimum for the group, namely five years. Therefore, each member of this cohort was followed for five years from the date of first admission. The same principle was applied to those admitted during each of the next four fiscal years, the period of exposure being reduced successively by a year. Thus, those admitted during the final fiscal period selected for this study (April 1, 1947 to March 31, 1948) were exposed for a period varying from one to two years, ending March 31, 1949. But to secure a uniform period for each member of the cohort, the period of observation had to be one year from the date of first admission for each member of the cohort. The periods of exposure varied, therefore, from a minimum of one year for those admitted during the year ending March 31, 1948 to five years for those admitted during the year ending March 31, 1944.

During the five fiscal years which began April 1, 1943 and ended March 31, 1948 there were 88,126 admissions to the New York civil state hospitals. These included 66,348 first admissions (that is, they had had no previous admission to a mental hospital). From these first admissions, there were excluded 1,775 who were transferred to or readmitted subsequently to a mental hospital which was not a part of the state hospital system. We were thus left with a total of 64,573 first admissions, 30,287 males and 34,286 females. Table 1 summarizes the five cohorts by year of first admission.

TABLE 1. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS,
FISCAL YEARS 1943-1944 TO 1947-1948, INCLUSIVE

<i>Fiscal Year</i>	<i>Males</i>	<i>Females</i>	<i>Total</i>
1943-1944.....	5,829	6,827	12,656
1944-1945.....	5,554	6,537	12,091
1945-1946.....	5,765	6,715	12,480
1946-1947.....	6,228	6,813	13,041
1947-1948.....	6,911	7,394	14,305
Total.....	30,287	34,286	64,573

Of the 64,573 first admissions, all but 10,058 (15.6 percent) were included in seven groups of mental disorders. The largest was dementia praecox, which included 16,571 cases (25.7 percent of the total). Psychoses with cerebral arteriosclerosis totaled 14,370 (22.3 percent), and the senile psychoses included 10,666 (16.5 percent). The two latter groups included 38.8 percent of the total first admissions. Together with dementia praecox, these three groups included almost two-thirds of the total first admissions. The complete distribution according to mental disorders is shown in Table 2.

A further classification is shown in Table 3 with respect to age at first admission.

The weighting with the aged is clearly evident. Of the 64,573 first admissions, those aged 70 years or over totaled 17,210 (26.7 percent). If we assume age 60 as the cutting-off point, then we include 26,424 (40.9 percent), as the group of advanced age. As is well known, first admissions of advanced age have been increasing steadily for several decades and now represent a major problem in state mental hospitals.

Though on a far smaller scale, attention must also be direc-

TABLE 2. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS,
FISCAL YEARS 1943-1944 TO 1947-1948, INCLUSIVE

(Classified According to Mental Disorders)

<i>Mental Disorders</i>	<i>Number</i> *			<i>Percent</i>		
	Males	Females	Total	Males	Females	Total
General paresis.....	2,140	783	2,923	7.1	2.3	4.5
Alcoholic	2,497	832	3,329	8.2	2.4	5.2
With cerebral arterio-sclerosis	7,271	7,099	14,370	24.0	20.7	22.3
Senile	4,209	6,457	10,666	13.9	18.8	16.5
Involutional	1,200	2,982	4,182	4.0	8.7	6.4
Manic-depressive ...	745	1,729	2,474	2.4	5.0	3.8
Dementia praecox ...	6,841	9,730	16,571	22.6	28.4	25.7
Other	5,384	4,674	10,058	17.8	13.6	15.6
Total	30,287	34,286	64,573	100.0	100.0	100.0

* Excluding those who were subsequently transferred to a licensed hospital.

ted to the youngest age group, those under 15. This group included 819 first admissions, of whom more than half were males. The group consisted primarily of those diagnosed as having behavior disorders, including a variety of emotional problems. It is only in recent years that this group has begun to show significant totals in admissions to the New York civil state hospitals.

TABLE 3. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS,
FISCAL YEARS 1943-1944 TO 1947-1948, INCLUSIVE

(Classified According to Age)

<i>Age (Years)</i>	<i>Number</i>			<i>Percent</i>		
	Males	Females	Total	Males	Females	Total
Under 15	592	227	819	2.0	0.7	1.3
15-19	1,346	1,212	2,558	4.4	3.5	4.0
20-24	1,789	2,029	3,818	5.9	5.9	5.9
25-29	1,786	2,406	4,192	5.9	7.0	6.4
30-34	1,895	2,607	4,502	6.3	7.6	7.0
35-39	1,989	2,589	4,578	6.6	7.6	7.1
40-44	2,083	2,360	4,443	6.9	6.9	6.9
45-49	2,003	2,320	4,323	6.6	6.8	6.7
50-54	2,082	2,358	4,440	6.9	6.9	6.9
55-59	2,243	2,093	4,336	7.4	6.1	6.7
60-64	2,372	2,066	4,438	7.8	6.0	6.9
65-69	2,396	2,380	4,776	7.9	6.9	7.4
70 or over.....	7,650	9,670	17,210	25.3	27.9	26.7
Unascertained	61	79	140	0.2	0.2	0.2
Total	30,287	34,286	64,573	100.0	100.0	100.0

This study will deal with the proportions of events (discharges, deaths, etc.) that occur within specified periods after first admission to the New York civil state hospitals. It is therefore necessary to define how we measure these periods. The interval has been taken usually as from the date of first admission to the date when the patient left the hospital, either by immediate discharge, by placement in convalescent care (parole), or by death. This is appropriate from an administrative viewpoint, since it is related directly to such problems as the availability of beds and expenditures for maintenance. The duration of hospital residence is also of deep concern to the patient and his family, since it represents time when he is limited in varying degree with respect to personal liberty.

We are also interested, however, in the question of the duration of a mental disorder. With this in mind, placement in convalescent care cannot be considered a suitable end-point. Psychotherapy is administered during the convalescent period. Various somatic therapies are also applied during this period. Thus, placement in convalescent care must be considered part of the entire treatment procedure.

The standards for placement in convalescent care may remain relatively constant in a given hospital. In a hospital system, however, the duration of the interval prior to such placement varies from hospital to hospital. Patients have short or long residences depending, in part, upon the attitudes of hospital administrators towards the use of convalescent care. This is an important consideration, because though 70 percent of patients are discharged by the New York civil state hospitals while in convalescent care, the percentage varies among the several hospitals from a minimum of 30 percent to a maximum of 85 percent.

Furthermore, from 30 percent to 40 percent of the patients placed in convalescent care subsequently return to the hospitals because of an exacerbation of the same illness. They pass back and forth from the status of in-patient to that of out-patient.

For these reasons, and because it is related more directly to the concept of the "natural history" of a disease, the interval employed in the following analysis begins with the date of first admission and ends with removal from the books, either

by discharge or by death. The majority of the patients so discharged were removed from the books while in convalescent care. However, a substantial number, almost 30 percent, were discharged directly from the hospitals.

Included in this study were 64,573 first admissions to the New York civil state hospitals. Of this total, 12,656 were followed for a period of five years from the date of their first admission, which occurred during the year ending March 31, 1944. Discharges from this group occurred during each of the five years ending in the fiscal year 1948-1949. The 12,091

TABLE 4. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS
DISCHARGED DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Percentage and Rate)

<i>Period of Hospitalization</i>	<i>Males</i>			<i>Females</i>		
	<i>Per- cent</i>	<i>Cumula- tive Per- cent</i>	<i>Rate per 1,000 Exposures*</i>	<i>Per- cent</i>	<i>Cumula- tive Per- cent</i>	<i>Rate per 1,000 Exposures*</i>
First three months.	9.5	9.5	453.4	6.7	6.7	309.2
Second three months	2.5	12.0	146.3	2.0	8.7	108.3
Third three months	1.3	13.3	84.6	1.0	9.7	57.4
Fourth three months	1.1	14.4	65.8	0.8	10.5	49.9
First year	14.4	14.4	166.5	10.5	10.5	119.8
Second year	21.5	35.9	395.4	26.5	37.0	429.1
Third year	3.8	39.7	134.2	4.2	41.2	136.0
Fourth year	1.6	41.3	74.1	1.6	42.8	66.7
Fifth year	0.7	42.0	36.4	0.7	43.5	32.9

* On an annual basis.

admitted during the fiscal year ending March 31, 1945 could be followed for a maximum of only four years. Thus, though this cohort contributed to the discharges of each of these years, it could not be included in discharges during the fifth year. In a similar manner, no discharges were recorded during the fourth year after admission from among the first admissions during the year 1945-1946. Finally, those admitted during 1948-1949 were followed for only one year and therefore did not contribute to the total of discharges during the subsequent years. Therefore, since each of the five cohorts was followed during the first year, the total discharges must be related to the total admissions or exposures during that period. However, discharges during the second year must be related only to the first four cohorts, since the final cohort (1947-1948)

dropped out from observation after one year. In the same manner, discharges during the third year must be based upon the first three cohorts, since only these cohorts were traced through the third year of hospitalization. Finally, the discharges of the fifth year were related only to the first cohort (1943-1944), since this was the only cohort followed for a period of five years.

Table 4 shows the percentages of the first admissions who were discharged during successive intervals after admission. The percentages through the first year were derived from the total first admissions in each of the five cohorts. The percentages during the second year are an average for the first four cohorts, and similarly through the remainder of the table. It is evident that there were very few discharges either directly from the hospital or from convalescent care after the second year of hospitalization. Whereas 35.9 percent of the male first admissions were discharged by the end of two years after admission, only 6.1 percent were discharged during the next three years. Fourteen percent of the first admissions were discharged during the first year. Within this period, most of the discharges occurred during the first three months. These consisted in part of patients who recovered rapidly from an acute onset (*e.g.*, from an alcoholic episode), and of others who were removed from the books by administrative procedures (such as a return to the courts after a period of observation). There were relatively few discharges during the remainder of the first year of hospitalization. Half of all the male discharges occurred during the second year. This was due in large part to the culmination of convalescent care during this period, most of such patients having been placed in convalescent care during the previous year.

The general trend was the same for females. There were more discharges during the first three months than during the remainder of the first year. The discharges were most numerous during the second year of hospitalization, and decreased rapidly after that. Relatively more males than females were discharged during the first year, but more females than males were discharged during the second year.

As noted previously, the high percentage of discharges during the second year after admission was due to the culmina-

tion of periods of convalescent care. However, of those so discharged, about 80 percent had been in convalescent care for from 12 to 18 months. It follows that about 20 percent of the first admissions discharged during the second year had left the hospitals during the first year. Therefore, those who left during the first year, either by direct discharge from the hospitals or by placement in convalescent care, represented approximately 30 percent of the cohorts. For the entire period of five years, the discharges from the books amounted to 42.0 percent for males and 43.5 percent for females. An earlier study of cohorts admitted to the New York civil state hospitals about 1910 gave corresponding percentages of discharge of 37.9 and 35.9 for males and females, respectively.¹ However, because of different procedures in recording discharges, the percentages for the current cohorts must be reduced by about a fifth, in order to achieve comparability. It then appears that current rates of discharge were lower than those for the earlier years, though the differences are not significant. The comparison is spurious, however, because the discharges are influenced by the relative proportions of first admissions with senile psychoses and psychoses with cerebral arteriosclerosis, who have low percentages of discharge. These groups represented 39 percent of the current cohorts, but only 13 percent of the older cohorts. Comparability will be achieved in subsequent analyses by limiting the cohorts to similar groups of mental disorders.

Percentages, however, do not give the rate (or probability) of discharge during each of the intervals after hospitalization. These must be obtained by relating the discharges not to the total first admissions but to those who were exposed to the chance of discharge during each interval. The rates per 1,000 annual exposures are shown in Table 4. Among males, the most rapid rate of discharge was during the first three months. The rate for this period was 453.4 per 1,000 annual exposures. It dropped to 65.8 during the final quarter of the first year of hospitalization. The average rate for the first year was 166.5. The rate rose to a maximum of 395.4 during the second year and then decreased to a minimum of 36.4 during the fifth year.

Females had a lower rate of discharge than males during

the first year. Beginning with a rate of 309.2 per 1,000 exposures during the first quarter, the rate decreased to 49.9 during the final quarter of the first year, with an average of 119.8 for the first year. The rate increased to 429.1 during the second year and then fell rapidly to 32.9 during the fifth year.

Because of the different methods of recording duration of hospitalization, the rates of discharge during the first year cannot be compared with those of the earlier cohort. By the end of the second year, however, discharges were comparable, representing in both cases discharges from the books. On this basis, the discharge rates for males within two years after hospitalization were 430 and 388 per 1,000 among the current and early cohorts, respectively. For the females, they were 437 and 352, respectively.² As noted previously, however, the rates for the cohorts of 1944 to 1948 must be reduced by a fifth, because of different methods of recording, in order to make them comparable with the older cohort. It then follows that there were no significant differences in rates of discharge. This must be ascribed to the higher proportion of first admissions of advanced age among the current cohorts.

The discharges varied inversely with the age at first admission. Thus, 33.3 percent of males aged less than 15 years at first admission were discharged within a year after hospitalization. The percentage discharged within this period decreased steadily with advancing age, reaching 20.3 percent among those aged 40 to 44 at admission and 11.8 percent among those aged 55 to 59. At older ages, the discharge rate decreased even more rapidly, dropping to 3.3 percent among those aged 70 years or over at admission. A similar trend was shown in every period of hospitalization from the date of first admission. During the first quarter of the first year, for example, the percentage of discharges declined among males from 9.0 among those aged less than 15 years to less than 1 percent among those aged 65 or over at admission. Because of the predominance of certain diagnostic groups, 33.3 percent of first admissions aged less than 15 years at admission were discharged during the first year, compared with only 16.0 percent during the second year. At subsequent ages, however, the percentage of those discharged during the second year declined steadily from a maximum of 37.3 percent at

TABLE 6. RATES OF DISCHARGE * AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION

(Classified According to Age at First Admission)

Age (Years)	Males										Females									
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th mos. †	1st year	2nd year	3rd year	4th year	5th year		
Under 15 ..	605.8	425.7	377.5	129.8	334.4	261.3	233.1	143.9	120.0	424.6	179.8	62.8	64.1	173.3	274.8	274.0	207.8	250.0		
15-19	627.7	253.0	192.8	135.8	271.8	522.7	201.2	112.8	52.2	435.2	231.7	127.0	65.6	199.8	536.9	255.3	98.1	80.6		
20-24	640.3	316.4	138.4	122.2	274.8	489.0	198.3	125.8	63.7	456.4	236.1	101.5	77.1	201.9	583.0	187.1	101.0	43.0		
25-29	710.4	239.1	157.7	90.1	272.9	430.4	169.8	93.4	46.5	444.8	208.8	96.4	80.5	193.9	532.0	200.4	86.4	18.7		
30-34	673.4	198.0	104.8	91.2	247.0	507.9	191.6	107.8	68.4	451.8	170.8	95.2	44.1	179.0	552.8	183.0	124.8	44.4		
35-39	662.9	170.5	81.9	89.6	231.9	495.3	174.1	91.6	41.7	408.1	144.6	69.0	51.4	169.2	533.8	168.6	67.4	47.1		
40-44	626.2	173.0	60.1	59.0	212.8	494.7	163.4	80.4	54.3	403.3	107.6	43.3	39.9	141.0	529.1	157.6	63.0	34.6		
45-49	552.3	150.8	69.2	54.6	192.4	465.8	177.2	73.7	32.6	314.3	83.4	59.1	45.5	119.0	479.4	157.7	87.1	39.1		
50-54	451.7	123.0	57.4	42.5	156.5	419.4	133.3	34.6	22.7	332.6	83.3	56.3	42.5	121.2	486.9	142.4	64.9	45.4		
55-59	385.7	101.3	58.6	39.2	134.8	405.7	129.4	74.4	13.7	284.2	54.2	28.3	50.9	97.8	423.2	140.0	83.5	9.8		
60-64	254.6	61.6	58.6	42.9	94.1	306.7	68.8	60.9	11.4	232.5	32.8	37.7	64.2	83.1	342.4	107.1	23.6	10.6		
65-69	233.8	21.5	29.4	35.0	47.7	255.2	70.4	58.2	...	174.6	33.1	33.0	55.9	65.7	202.0	73.1	32.3	11.8		
70 or over ..	141.8	41.8	28.2	29.2	71.7	138.1	28.1	23.2	8.6	120.8	32.3	15.1	25.8	41.4	121.6	22.5	14.9	13.7		

* Per 1,000 annual exposures.

† On an annual basis.

ages 15 to 19 to a minimum of 4 percent among those aged 70 or over. Discharges were few after the second year. Nevertheless, each period showed the same declining trend in relation to advancing age at time of hospitalization. During the third year, discharges decreased from 9.9 percent at ages under 15 to 0.4 percent at ages 70 or over. During the fourth year, the percent discharged declined from 4.8 to 0.3. During the fifth year, the percent declined from 3.3 to 0.1.

Female first admissions showed the same trend as males. During the first three months after admission, the percentages discharged decreased from 10.6 in the youngest age group to 2.1 among the oldest. During the first year, the percentages declined from close to 20 percent at the youngest ages to 3 percent among those aged 70 or over. During the second year, the percentages declined from over 40 percent at the youngest ages to 4 percent at the oldest. During the fifth year, they declined to less than 1 percent.

A further description of the inverse relation between rates of discharge and age at first admission is shown in Table 6. This table summarizes the *probability* of discharge during each period subsequent to admission, these being further classified according to age at admission. Rates of discharge were highest during the first three months after admission. But they declined among males during this interval from over 600 per 1,000 annual exposures to less than 200 in the older age groups. For the entire first year, the rates declined from over 300 per 1,000 annual exposures among those aged less than 15 years at admission to less than 100 among those aged 60 or over. Each subsequent period after admission to the hospitals showed similar declines in rates of discharge with advancing age at time of admission.

Females showed the same trend as males with respect to the inverse relation between age at first admission and subsequent rates of discharge. During the first year after first admission, females showed smaller probabilities of discharge than males. However, these probabilities declined from approximately 200 per 1,000 annual exposures at the youngest ages to less than 100 at the oldest ages. During the second year after admission, the probabilities of discharge were highest, but they declined from over 500 per 1,000 annual exposures at

the youngest ages to less than 120 at age 70 or over. As shown previously, rates of discharge declined after the second year of hospital life, but in each period the rate of discharge was higher among the younger than the older admissions.

There is a similar inverse relation between rate of discharge and the estimated duration of the mental disease prior to admission to the hospital. Two qualifications must be made, however. In the first place, estimates of the duration of a disease cannot be as reliable as statements of chronological age. Consequently, the indices of discharge in relation to prior duration of a disease do not show the same degree of regularity of trend. Nevertheless it is clearly evident (see Table 7) that the percentage discharge during the first and second year after admission to the hospitals was highest among those with short prior durations and lowest among those with long durations. The trend was especially evident among the female admissions.

A second qualification relates to rates of discharge after the second year of hospitalization when these are correlated with the prior duration of the disease. There was little, if any, variation of rates of discharge during these periods when they were related to the prior duration. It has been shown that rates of discharge are, in general, low after the second year of hospitalization. A longer or shorter history of disease therefore has little effect upon the outcome after a long period of hospitalization, since the groups have all become chronic.

Table 8 provides a further description of the relation of discharge to the duration of the disease before hospitalization. This table gives rates (probabilities) of discharge per 1,000 annual exposures during each period subsequent to hospitalization, correlated with the prior duration of the disease. During the first two years after admission, the rates of discharge were clearly greater for those with short previous histories, and they became smaller as the prior duration increased. This was especially evident among females. The duration of the mental disorder was unascertained in a large proportion of the cases, especially among the males. However, if it were assumed that all unknown cases belonged to

TABLE 9. DISCHARGES AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943-1944 TO 1946-1947, INCLUSIVE, WITHIN TWO YEARS AFTER ADMISSION
(Classified According to Condition at Discharge)

Condition at Discharge	Males			Females			Total		
	Number	Percent of Total Discharges	Percent of First Admissions	Number	Percent of Total Discharges	Percent of First Admissions	Number	Percent of Total Discharges	Percent of First Admissions
Recovered	2,906	34.8	12.4	3,923	39.2	14.6	6,829	37.2	13.6
Much improved..	2,582	30.9	11.0	3,309	33.1	12.3	5,891	32.1	11.7
Improved	1,822	21.8	7.8	1,992	19.9	7.4	3,814	20.8	7.6
Unimproved	659	7.9	2.8	630	6.3	2.3	1,289	7.0	2.6
Without psychosis	392	4.7	1.7	141	1.4	0.5	533	2.9	1.1
Total discharges.	8,361	100.0	35.8	9,995	100.0	37.2	18,356	100.0	36.5
Total first admissions	23,376	.....	....	26,892	.....	....	50,268	.....	....

the category of a prior duration of more than five years, the rate of discharge would still be less than that shown by first admissions with histories of short prior durations.

Table 9 summarizes the condition of the patients at time of discharge. The interval was taken as two years after admission. This period was chosen because it has been shown that the two years following admission are the crucial periods. Thereafter, we are presented with a residue of patients who are largely chronic. In addition, it was necessary to exclude the cohort of 1947-1948, since this group had an experience of only one year.

The remaining four cohorts included 50,268 first admissions. Of this total, 18,356 (36.5 percent) were discharged within two years after admission. Those discharged as recovered represented 13.6 percent of the total first admissions. Those who were much improved and improved represented 11.7 percent and 7.6 percent respectively. The total with some degree of improvement therefore represented 32.9 percent. The sex differences, though small, favored the females. Rates of recovery were 12.4 percent and 14.6 percent for males and females, respectively. Corresponding percentages for all degrees of improvement were 31.3 and 34.3, respectively. These all exceed corresponding percentages for the early cohort. For the latter, all degrees of improvement showed the following percentages: males, 26.7; females, 24.1; both sexes, 25.4.³

MORTALITY

As explained in the previous sections, all the cohorts were exposed to a follow-up of at least one year after admission to the hospitals. In each subsequent year, one cohort dropped out of the total of exposures, until only one cohort, that of 1943-1944, remained through the fifth year. Therefore, the mortality during each year of hospital residence must be related only to the cohorts who were exposed to the risk of death during the corresponding period. The measures of mortality are therefore an average for each period subsequent to the dates of first admission.

Among males, the deaths averaged 27.4 percent of the total admissions during the first year. This was, by far, the period of heaviest mortality. The percentage of patients dying dur-

ing the entire period of five years grew to only 39.0, an addition of only 11.6 percent during four years. Within the first three months after admission, the mortality averaged 18.0 percent of the total admissions. The percentage of mortality decreased rapidly thereafter.

Females had lesser mortality than males throughout the five years. Of the total first admissions, 15.4 percent died within three months. The percentage grew to 24.4 by the end of the first year, compared with 27.4 percent for males. Only 5 percent of the females died during the second year after admis-

TABLE 10. FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS
DYING DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Percentage and Rate)

Period of Hospitalisation	Males			Females		
	Per- cent	Cumulative		Per- cent	Cumulative	
		Per- cent	Rate per 1,000 Exposures*		Per- cent	Rate per 1,000 Exposures*
First three months.	18.0	18.0	786.1	15.4	15.4	652.8
Second three months	4.5	22.5	256.6	4.3	19.7	223.4
Third three months.	2.8	25.3	176.3	2.7	22.4	157.5
Fourth three months	2.1	27.4	142.1	2.0	24.4	120.4
First year	27.4	27.4	296.2	24.4	24.4	257.9
Second year	4.8	32.2	103.4	5.0	29.4	98.8
Third year	3.1	35.3	109.3	2.9	32.3	94.2
Fourth year	2.1	37.4	96.7	2.1	34.4	84.9
Fifth year	1.6	39.0	88.6	1.8	36.0	74.0

* On an annual basis.

sion. By the end of the fifth year, 36.0 percent had died, compared with 39.0 percent of the males.

The preceding percentages are directly comparable with those for the early cohort, since they are all based upon deaths occurring in the hospitals. Of the early male cohort, 34.8 percent died within five years, compared with 39.0 percent of the current male cohorts. Among females, the corresponding percentages were 30.5 and 36.0, respectively.⁴ At every period subsequent to admission to the hospitals, the current cohorts had greater mortality. As with discharges, this resulted from the greater prevalence of the psychoses of old age among the current cohorts.

The actual risks of mortality, however, can only be shown by relating deaths, not to the total first admissions, but to the

number who were exposed to such risk during each period. Since the population under exposure was reduced steadily, both by previous discharges and by previous deaths, the absolute number of deaths would necessarily be smaller in successive periods unless there had been considerable increases in the rates of mortality. When expressed in terms of deaths per 1,000 annual exposures, the results were as follows. The heaviest mortality among males, 786.1 per 1,000 annual exposures, occurred during the first three months after hospitalization. The rate dropped rapidly during the remainder of the first year, and averaged 296.2 for that period. The rate decreased by 65 percent during the second year of hospitalization, and continued to decrease, reaching a minimum of 88.6 during the fifth year.

Among females, the trend of the death rates per 1,000 annual exposures was similar to that for males. Mortality was heaviest during the first three months, averaging 652.8 per 1,000 annual exposures. The rate then decreased to 120.4 during the final quarter of the year, and averaged 257.9 for the entire year. The corresponding rate for males during the first year was 296.2. The rate decreased rapidly to 98.8 during the second year, and was 74.0 during the fifth year. Even in this period of relatively low mortality, the rate for males exceeded that for females by 20 percent.

These death rates may be compared with corresponding rates for the early cohort.⁵ During the first three months of hospitalization, the early male cohort had a rate of 677.7, compared with 786.1 for the current cohort. For the first year, the average rates of mortality were 248.2 and 296.2, respectively. In every period of hospitalization, the current cohort had a higher rate of mortality, ending with a rate of 88.6 during the fifth year, compared with 40.2 for the early cohort.

Rates of mortality were lower for females than for males, but throughout the entire period of hospitalization the rates for the early female cohort were lower than those for the current cohorts. During the first three months, the rates were 469.4 and 652.8, respectively. During the first year, they averaged 211.9 and 257.9, respectively. During the fifth year, they were 68.6 and 74.0, respectively. The higher death rates of the current groups were due primarily to the great increase of

the number of older admissions, who have higher death rates than other groups with mental disorders.

It was shown in the preceding sections that rates of discharge varied inversely with age at first admission. The older the admissions, the lower the rate of discharge. Mortality, on the other hand, increased directly with age. Thus, the older the first admissions, the greater the mortality.

Table 11 shows the percentage of first admissions who died in successive periods after hospitalization, classified according to age at admission. In every age group, the highest percentages occurred during the first year. In each period since first admission, however, the percentage increased from the youngest to the oldest groups at time of admission. Among males, the percentage dying during the first three months after admission increased from less than one percent at the youngest ages to more than 40 percent at ages 70 or over. During the first year, they grew from one percent to over 60 percent with advancing age at first admission. The percentages of deaths after the first year were low, but nevertheless they too showed the same rising trend with increasing age at first admission. During the second year after hospitalization the percentages increased from less than one percent to nine percent, in accordance with increasing age. Among females, the percentage of patients dying during the first year of hospitalization varied from one percent and two percent at the younger ages to 55 percent among those who were admitted at ages 70 or over. Each period of hospitalization showed a similar rising trend from minimum percentages of those dying among the younger admissions and maximum percentages at the older ages.

We may consider next the actual rates of mortality per 1,000 annual exposures. These were highest during the first three months of hospitalization. During this period, they rose for males from approximately 40 per 1,000 among those aged less than 20 at time of first admission to 886.8 among those aged 60 to 64. At higher ages, the total cohort would have died in less than a year after hospitalization, if the rate for the first quarter had continued throughout the year. During the first year, the average death rate for that period grew from 12.2 to 627.7 in accordance with increasing age at first admission. During the second year of hospitalization, the death rates increased from 4.2 to 288.9.

TABLE 11. PERCENT OF FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DYING DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Age at First Admission)

Age at First Admission (Years)	Males					Females												
	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	1st three mos.	2nd three mos.	3rd three mos.	4th three mos.	1st year	2nd year	3rd year	4th year	5th year				
Under 15 ...	0.8	...	...	0.2	1.0	0.2	0.6	0.4	...	0.4	0.9	...	0.4	1.8	...	...	1.1	...
15-19	0.7	0.4	0.1	0.1	1.2	0.4	0.4	0.4	0.4	0.7	0.2	...	...	0.9	0.4	0.4	0.2	...
20-24	1.3	0.2	0.2	0.1	1.8	0.6	0.3	...	0.3	1.7	0.2	0.1	0.2	2.3	0.4	0.6	11.3	0.5
25-29	1.5	0.4	0.5	0.2	2.6	0.7	0.4	0.2	0.6	1.1	0.4	0.2	0.3	2.0	0.7	0.6	0.3	0.4
30-34	1.8	0.7	0.4	0.4	3.4	0.4	0.5	1.1	0.6	2.1	0.7	0.3	0.2	3.3	0.5	0.8	0.9	0.6
35-39	4.7	1.8	0.7	0.3	7.4	1.6	1.2	0.4	0.5	2.7	0.9	0.6	0.2	4.4	0.9	0.4	0.5	0.2
40-44	6.3	1.3	0.8	0.7	9.2	2.2	1.6	0.2	0.4	4.8	0.6	0.6	0.6	6.5	1.6	0.9	0.4	0.7
45-49	8.1	2.6	1.6	1.4	13.7	3.0	1.0	0.8	...	6.4	1.6	1.3	0.9	10.2	1.6	1.0	1.3	1.0
50-54	11.7	3.7	2.3	1.3	18.9	3.6	3.8	1.4	1.5	8.8	2.4	1.4	1.4	13.9	3.0	1.4	1.9	1.2
55-59	15.4	4.5	3.3	2.1	25.4	4.1	2.6	1.9	1.8	13.6	2.9	2.3	2.3	21.1	4.8	3.1	1.6	2.2
60-64	21.2	5.9	3.9	3.2	34.2	7.2	4.7	3.5	1.8	20.1	4.9	3.3	2.7	31.0	5.6	4.4	2.1	2.6
65-69	27.8	6.6	4.8	3.5	42.7	8.7	5.7	3.6	3.4	24.1	7.3	4.0	3.4	38.8	8.8	4.9	3.3	2.4
70 or over ..	41.8	9.7	5.8	4.5	61.7	9.1	5.5	3.8	2.8	34.7	10.0	6.6	4.3	55.6	11.3	5.8	4.2	2.7

TABLE 12. RATES OF MORTALITY * AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Age at First Admission)

Age at First Admission (Years)	Males										Females									
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st year	2nd year
Under 15	38.9	.....	.....	10.2	12.2	4.2	16.9	15.4	.....	19.4	41.2	.....	21.6	19.3	.....	.....	.....	.....	.....	.....
15-19	31.0	18.8	4.0	4.1	13.7	7.4	13.4	15.8	17.7	32.8	7.9	.....	.....	10.1	7.3	13.2	7.9	.....	.....	.....
20-24	62.3	8.7	12.1	6.3	21.4	11.6	10.9	.....	13.1	70.5	11.9	7.4	10.1	25.7	6.9	20.1	10.6	21.7	.....	.....
25-29	71.4	23.3	27.6	9.4	30.4	13.0	13.4	6.5	23.5	47.8	17.8	10.2	14.7	35.8	12.0	17.8	12.2	18.7	.....	.....
30-34	83.9	35.1	25.3	26.0	39.0	7.9	15.9	39.1	28.0	93.4	31.2	15.2	9.7	85.8	9.4	26.9	35.6	26.9	.....	.....
35-39	219.6	92.0	38.8	17.1	84.3	29.5	38.0	16.8	21.1	116.8	43.8	28.2	11.5	47.7	15.5	14.8	18.1	8.0	.....	.....
40-44	291.1	70.8	44.6	37.7	102.1	41.7	52.3	43.4	22.1	209.2	28.4	26.9	29.4	70.0	26.8	26.0	15.2	26.1	.....	.....
45-49	364.4	135.7	88.1	82.8	150.8	57.7	84.2	32.3	.....	276.6	73.4	61.2	47.7	108.3	27.5	27.8	42.8	32.7	.....	.....
50-54	514.4	191.8	126.6	76.0	203.7	68.6	86.1	53.8	66.7	376.4	115.8	69.1	73.4	147.4	52.3	42.6	68.6	45.4	.....	.....
55-59	697.5	243.9	188.8	131.6	270.0	85.0	87.3	84.7	104.6	576.2	144.8	123.6	126.4	220.8	86.3	88.2	55.1	84.5	.....	.....
60-64	886.8	326.9	235.6	211.8	356.2	148.2	147.9	147.7	88.4	838.7	204.7	193.4	164.4	321.5	110.5	129.8	78.2	110.6	.....	.....
65-69	(1000.0)	390.8	320.2	254.1	439.8	195.3	197.3	169.6	195.1	903.0	406.2	251.4	229.2	398.8	182.3	157.2	139.4	132.6	.....	.....
70 or over...	(1000.0)	696.7	506.2	457.7	627.7	288.9	280.6	290.7	332.1	(1000.0)	636.0	502.2	376.2	654.7	295.3	248.7	250.4	213.6	.....	.....

* Per 1,000 annual exposures.

† On an annual basis.

Females showed the same trend. During the first three months the death rates grew from 19.4 among those less than 15 years of age at time of admission to 993.0 at ages 65 to 69. If continued throughout the first year, the death rate among those admitted at age 70 or over would have been 100 percent. However, the rates decreased rapidly after the first period of hospitalization of three months, the average for the first year being considerably lower. The average rate for the first year decreased from less than 20 per 1,000 among those admitted at ages under 20 to almost 600 for those admitted at 70 or over. During the second year of hospitalization, the rates increased with advancing age at first admission from seven to almost 300 per 1,000.

Attention should be directed to the important fact that after the second year of hospitalization the death rates were stabilized at a very low level.

The relation between the duration of the mental illness before hospitalization and subsequent mortality is not as clear-cut as that shown with respect to age. This may be due to the difficulties of estimating exact durations, when symptoms have developed over many years. Nevertheless, it appears that the average mortality after hospitalization is lower among those with short previous histories and higher among those with long histories. The relation may be due, in part, to the fact that those with long histories of disease are also likely to be older.

Table 13 shows the percentage of deaths occurring during specified periods of hospitalization in relation to the duration of the mental disease before hospitalization. During the first year, the percentage of patients dying increased among males from approximately 25 percent among those with short previous histories to over 30 percent among those with long histories. During the second year, the percentage grew from an average of about four percent among those with short prior durations to almost six percent among those with longer prior durations. This trend was even more marked among females.

Table 14 gives the rates of mortality per 1,000 annual exposures. That these rates vary directly with the duration of the mental disease prior to hospitalization is evident. During the first year of hospitalization, the rate grew among males

TABLE 14. RATES OF MORTALITY * AMONG FIRST ADMISSIONS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION
(Classified According to Duration of Mental Disease Before Admission)

Duration of Mental Disease before Admission	Males									Females								
	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year	1st three mos. †	2nd three mos. †	3rd three mos. †	4th three mos. †	1st year	2nd year	3rd year	4th year	5th year
Less than one month ...	727.6	207.2	131.4	112.8	251.9	85.9	92.3	79.1	99.6	474.4	100.6	98.0	73.9	179.0	52.3	95.0	73.1	43.7
1-3 months	745.4	215.4	140.4	114.4	270.3	88.6	100.8	111.4	100.2	582.3	156.9	112.7	76.5	212.5	64.1	62.5	70.4	73.0
4-6 months	777.6	242.0	145.9	115.8	283.1	119.9	109.3	92.2	20.5	517.9	223.7	124.2	99.5	216.4	90.7	72.1	74.6	69.8
7-11 months	619.8	285.0	117.2	94.9	248.0	117.5	100.0	78.8	114.9	581.3	214.3	131.2	104.3	232.0	90.4	81.0	93.5	65.6
1 year	874.5	302.3	200.6	136.9	329.6	121.8	126.7	122.1	82.8	652.1	281.4	191.3	148.5	277.0	120.2	99.6	86.8	58.8
2 years	882.4	354.0	293.4	237.0	370.8	120.0	182.5	90.2	74.1	771.4	327.2	194.8	173.1	319.7	138.8	108.4	103.4	74.1
3 years	902.2	259.2	191.3	189.8	335.0	111.1	134.1	62.1	....	743.1	307.3	222.5	153.2	312.1	149.9	137.4	118.1	108.7
4 years	801.6	391.1	290.3	114.1	342.1	99.2	109.1	96.4	....	711.6	299.9	246.4	146.6	309.0	146.5	114.0	132.0	116.3
5 years or over	794.4	250.4	194.9	166.8	306.4	107.2	78.9	68.2	75.7	623.9	232.3	197.4	163.4	270.0	115.4	89.5	80.9	92.2

* Per 1,000 annual exposures.

† On an annual basis.

from 251.9 among those with a very short history to over 300 among those with long histories. Among females, they varied during the first year of hospitalization from approximately 200 to over 300 in relation to the prior duration of the disease. As the periods of hospitalization grew to more than two years, the rates of mortality grew smaller and smaller, and tended to stabilize themselves, so that shorter or longer histories of prior mental illness did not affect significantly the size of the subsequent death rates.

The processes of discharge and death result in residues of patients at the end of specified periods of hospitalization. The percentage of such patients remaining continuously on

TABLE 15. PERCENT OF FIRST ADMISSIONS REMAINING IN CONTINUOUS RESIDENCE AT END OF SPECIFIED PERIODS AFTER ADMISSION

<i>Period</i>	<i>Males</i>	<i>Females</i>
End of third month.....	72.4	77.9
End of sixth month.....	65.4	71.7
End of ninth month.....	61.3	67.9
End of first year.....	58.1	65.0
End of second year.....	30.6	32.8
End of third year.....	23.1	25.3
End of fourth year.....	18.8	21.4
End of fifth year.....	16.4	19.4

the books at each specified period is shown in Table 15. As with discharges and deaths, it was necessary to adjust for the fact that the cohorts were exposed for varying periods. The first cohort, that for 1943-1944, was followed for a period of five years. Succeeding cohorts were exposed for lesser periods, ending with only one year for the cohort of 1947-1948. In consequence, the percentage at the end of the fifth year after first admission could be derived only from the experience of the cohort of 1943-1944. From this and the succeeding cohort, it was possible to obtain an average percentage of those remaining at the close of the fourth year. This was continued backward until all five cohorts were included in the experience of the first year after hospitalization. Thus, the percentages on the books after continuous residences of three, six, nine, and twelve months are based upon the experience of all five cohorts.

It appears that within three months, the average percentage of males remaining continuously on the books was 72.4. The

rapid reduction during this period was due to the fact that discharges and deaths were both numerous during this period. At the end of the first year, 58.1 percent of the males were still on the books. Thus, whereas 27.6 percent of the males were removed from the books during the first three months, only 14.3 percent were removed during the next nine months. At the end of the second year of hospitalization, 30.6 percent of the males were still on the books. This rapid increase of removals during the second year resulted primarily from the termination of placements in convalescent care, most of these placements having occurred during the previous year. After the second year, discharges were relatively few, but mortality increased. In consequence, the percentage of male patients remaining on the books was only 16.4 at the end of the fifth year.

Females were removed from the books at a slower rate than males throughout the entire period. Thus, 77.9 percent were on the books at the end of three months, compared with 72.4 percent of the males. At the end of the first year, the percentages were 65.0 and 58.1 for females and males, respectively. The disparity was reduced by the end of the second year, the percentages having become 32.8 and 30.6 for females and males, respectively. This was due to the greater rate of discharge for females during this period. Finally, at the close of the fifth year, the percentage of females on the books was 19.4, compared to 16.4 for the males.

The greater hospital life of females may be emphasized by the fact that the median duration for females was 17.6 months, compared to 15.5 months for males.

The preceding data refer to patients on the books after periods of continuous residence in the hospitals. If, however, we include patients who were readmitted after discharge from the books it then appears that 20.3 percent of the male cohort were on the books at the end of five years, compared with 23.1 percent of a male cohort admitted during 1909-1910.⁶ For females, the corresponding percentages were 24.4 and 28.5. The primary reason for the difference lies in the greater mortality of the current cohorts, arising from the increased admissions of patients with senile and arteriosclerotic mental disorders.

We now have a summary description of what happens to first admissions to the New York civil state hospitals within a period of five years after admission. To obtain the results, we combined and arranged the data for five successive cohorts of first admissions. Included in these cohorts were those first admissions who had spent the complete interval between admission and discharge from the books within the state hospital system. The first cohort was admitted during the fiscal year ending March 31, 1944, and each member of the cohort was followed for a maximum period of five years from date of admission. Since the closing date of the period of observation was March 31, 1949, the members of successive cohorts were under observation for a year less than each preceding cohort. Thus, the members of the fifth cohort, consisting of first admissions during the fiscal year 1947-1948, were followed for only a year from date of admission. Percentages and rates of discharge and death were derived from successive intervals after first admission, and in each case they were based upon the members who were exposed to risk during such intervals.

On the basis of average percentages of annual discharges, 42.0 percent of the male first admissions were discharged from the books within five years after admission. The most rapid period of discharge was the first three months after admission. During this period, the rate of discharge was 453.4 per 1,000 annual exposures. The rate dropped rapidly during the remainder of the first year, and averaged only 166.5 for that period. The rate rose to 395.4 per 1,000 during the second year, and then decreased to 36.4 per 1,000 during the fifth year. The rate of discharge was high during the second year, because of the culmination of periods of placement in convalescent care, about 80 percent of which had begun during the first year. It follows, therefore that approximately 30 percent of the male first admissions had left the hospitals within one year, either by direct discharge from the hospital or by placement in convalescent care.

The trend for females was similar to that for males, but the discharge rates were at a lower level, especially during the first year. As in the case of the males, it may be estimated that approximately 30 percent left the hospitals during the

first year, either by discharge or by placement in convalescent care.

There was a marked inverse relation between the rate of discharge and the age at first admission. The older the groups at admission, the lower the rates of discharge. A similar inverse relation, though not so marked, existed with respect to the estimated duration of the mental disease before admission to the hospital. The longer the prior duration, the lower the rate of discharge.

As with rates of discharge, the first three months after admission were also crucial with respect to mortality. Thus, 18 percent of the male first admissions died during this period, compared with an average of 27.4 percent for the entire first year. During the first three months, patients died at the rate of 786.1 per 1,000 annual exposures. The death rate dropped very rapidly after this period, and continued to decrease to a minimum rate of 88.6 during the fifth year.

The trend was the same for females, though in each period of hospitalization the rate for females was less than that for males.

There was a marked direct relation between rates of mortality and age at first admission. The rates increased steadily with advancing age at hospitalization. There was a positive but low degree of correlation between rates of mortality after hospitalization and the duration of the mental illness before hospitalization. This may be due, however, to the fact that those with long prior histories of disease may also be older at time of hospitalization.

As a consequence of discharges and deaths, the number of first admissions remaining continuously on the books after hospitalization decreased steadily. Among males, the average percentage at the end of three months was 72.4. This dropped to 58.1 percent at the close of the first year, and to 30.6 percent at the close of the second year. After this year, discharges and deaths were both reduced significantly, resulting in a low rate of further decrease among the patients, who then constituted a chronic group. At the end of the fifth year, 16.4 percent were still on the books. At this period of hospital life, the percentage on the books is, for practical purposes, equal to the percentage actually in residence.

Primarily as a result of lower death rates, the percentages of females remaining on the books at the close of specified periods exceeded the corresponding percentages for males. At the end of the crucial period of three months following admission, 77.9 percent of the female cohorts were still on the books. This decreased to 65.0 percent at the end of the first year, to 32.8 percent at the end of the second year, to 19.4 percent at the end of the fifth year.

The median durations of hospital life from admission to discharge from the books were 17.6 months for females, and 15.4 months for males.

These rates of discharge and death, and consequently the percentages of patients in continuous residence at the close of stated periods, are averages for the cohorts of first admissions. Whether rates be high or low depends primarily upon the types of patients entering into the cohorts. Patients with psychoses of advanced age constitute a different order of risk from other groups of patients who enter the mental hospitals at considerably younger ages. Succeeding parts of this investigation will, therefore, treat separately the "natural history of hospital life" of cohorts consisting of members of the seven largest groups of first admissions to the New York civil state hospitals.

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3. Computed from data in "Hospital Departures and Readmissions Among Mental Patients During the Fifteen Years Following First Admissions," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, No. 4, October 1930, p.659.
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6. See reference 1, p.301.

BOOK REVIEWS

MENTAL HEALTH PLANNING FOR SOCIAL ACTION. By George S. Stevenson, M.D., Sc.D. New York, McGraw-Hill Book Company, 1956. pp. ix + 358.

Many a mental health association begins its career as an enthusiastic core of dedicated people who are humanitarian in their attitude and are convinced that lay citizens have a great deal to contribute to problems of mental health and the treatment of the mental illnesses. Unfortunately, since much of the initial planning is done on the basis that it is good to discuss matters in groups and that these discussions will of themselves produce tangible results, all too often the organization finds itself "all dressed up with no place to go." The inevitable result is frustration on the part of the members, inability to extend the influence of the organization, and a great deal of wasted energy.

From any point of view this sequence of events is regrettable. In this particular field it is tragic, for it is certainly obvious by now that the problems of the mental illnesses cannot be solved by waiting for fairy godmothers in the research laboratories to come up with panaceas or by hoping that in some mysterious way greater numbers of trained personnel can be produced. An interested and really effective total social approach is the one which offers most possibility in the light of our present knowledge of the field. We cannot afford to waste this potential source of power in unproductive community meetings, however lofty the aims of those well-meaning groups.

In this situation this book provides from the broad background of the author a document as practical as a road map. The traveler in the uncharted areas of community participation can, in these pages, find constant reference points with which he can check his progress and plan his further trips. Dr. Stevenson is able to offer not only a great mass of factual material but also to make of this foundation a springboard for flights into far-reaching suggested plans which mental health organizations can and should carry out.

The book is divided into sections. Part One deals with an overall perspective of the problem with specific notes on program planning and criteria by which on-going and proposed programs can be constantly evaluated and re-evaluated. Part Two has 14 chapters on the various aspects of the mental illnesses with a great deal of useful information on the general care of the mentally ill as well as on the problems of the mentally deficient, narcotic addiction, the Veterans Administration program, and the legal aspects of the various problems of follow-up care and rehabilitation. Part Three deals with the general problem of prevention, Part Four with mental health in its rela-

tion to the various aspects of society, and Part Five with a down-to-earth discussion of mental health organizations including the problem of world mental health. A very practical appendix contains a categorized list of available visual aids.

Interspersed with these descriptions of existing facilities and suggestions as to various types of practical programs, the author has placed some of his own progressive ideas regarding possible ways of improving the *status quo*. He mentions such matters as the augmentation of the general hospital care of psychiatric patients, the usefulness of agencies not formally labeled as "psychiatric" but providing invaluable service nonetheless, the dangers inherent in professional isolation, and the advantages of decentralization of hospitals. Some readers will dislike these ideas, for they will not suit the psychiatrist who lacks a sense of community responsibility, the state hospital superintendent who defines expansion in terms of increasing his own isolated empire, and the social agencies which prefer to exist in a vacuum. It may be that mental health associations will find professional workers in their communities who will subtly but definitely resist the broad planning necessary for a concerted attack; Dr. Stevenson has provided here sufficient ammunition to make complacency uncomfortable.

The book should have many uses. Perhaps one which fits in with the author's general intent would be as a textbook for a workshop involving interested citizens with discussion groups to elaborate on the material contained in these pages. It seems almost inevitable that such an arrangement would result in a period of new growth and revitalized productive activity in almost any organization dealing with the problem of the mental illnesses.

C. H. HARDIN BRANCH, M.D.

University of Utah

CHILDREN IN PLAY THERAPY; A KEY TO UNDERSTANDING NORMAL AND DISTURBED EMOTIONS. By Clark E. Moustakas. (New York, McGraw-Hill Book Company, 1953. 218 p.

This volume on the nature and value of play therapy in the adjustment of both normal and disturbed children is written primarily for parents and teachers. Dr. Moustakas follows the techniques of "non-directive therapy" as developed by Carl Rogers and as applied, specifically, to children by Virginia Axline. The Rogerian method emphasizes a permissive approach "which allows the individual to articulate with growing confidence what he thinks and feels."

When the author states that "the three basic attitudes in child-centered play therapy are faith, acceptance, and respect," he is voicing not only the attitude to be employed by a non-directive therapist, but what should also be the approach of an understanding teacher or

parent. Unfortunately, however, few teachers have classes small enough to enable them to carry out this approach, even when they are capable of doing so.

This reviewer agrees with Dr. Moustakas that no attempt should be made in play therapy to interpret to the child the symbolism involved in his play, but rather that the child should be encouraged to express what the play means to him.

Dr. Moustakas expresses positive faith in the children's potentialities in his "belief that children have within themselves capacity for self-growth and self-realization." He illustrates this approach by transcriptions of tape recordings of actual play therapy episodes. In these recordings, examples are offered of the way in which children work out their hostilities against their parents, and their jealousy at the birth of a brother or sister; one long study illustrates how parents as well as child were helped to work through their emotional difficulties.

In the report on "Play Therapy with a Pre-School Family" the child described showed evidence of a severe phobic condition. The report tells of marked improvement in overcoming obsessive-compulsive behavior and a disappearance of fears during play therapy sessions, as well as an easing of the parents' pressures on this only child, which, according to the therapist, "helped Kathy to achieve more positive attitudes toward herself and others and to be more emotionally comfortable." Although this child was temporarily relieved of fears and tensions, her unresolved anxieties might later need more intensive treatment than was offered by such non-directive therapy. The question remains open, therefore, whether the permissive and sympathetic response of the Rogerian therapist can resolve severe unconscious conflicts.

The author reports on the way some children in play therapy sessions are interested in undressing both boy and girl dolls. But the Rogerian technique of affirming or repeating the child's own words may not uncover the child's un verbalized questions about birth and sex, nor will it necessarily reveal a child's unconscious symbolic responses.

While some of the recorded play sessions show positive therapeutic results, a doubt remains as to the final consequence of such treatment in more severe cases. Will it be enough for some of these children to express to the therapist their hostility against a parent? Or will regression to an infantile state be enough to release emotional difficulties in a lasting way? Or will entering into a fantasy world in a few play therapy sessions be sufficient to help the child make a satisfactory adjustment to reality?

Dr. Moustakas explains that as children play out their attitudes of

hostility, anxiety, and regression in his presence, such emotions will be released and transformed into more positive feelings. This may happen frequently with mildly disturbed children, but this may not be the inevitable conclusion (as stated by Dr. Moustakas) that "the child's emotional problems and symptoms are reflections of his attitudes, and as the attitudes change the problems and symptoms disappear." For in many cases an emotionally disturbed child's attitudes are defensive responses to mishandling by one or both parents. If the parents are not dealt with directly, when such a child is severely disturbed, a permanent recovery may not be possible.

Dr. Moustakas, a staff member of the psychology and mental hygiene department at the Merrill-Palmer School in Detroit, has had an unusual opportunity to orient parents as well as teachers to the value of play therapy in working through the emotional problems of young children. He seems over-optimistic, however, in his claim that "most parents seem to accept the fact that emotional frustrations and disturbances in children are frequently motivated by an impairment in family relationships which often is rooted in early family experiences. They understand that a troubled child may have a history of experiences where he was made to feel incapable, insecure, and inadequate, and that these feelings of worthlessness often pervade everything the child does and prevent him from functioning effectively. Many parents accept the idea that feelings of inferiority may arouse anger and guilt and fear, and that the more severe the child's sense of personal unworthiness and rejection, the more likely is he to have deep underlying feelings of anxiety and hostility."

Dr. Moustakas' comments on the readiness of parents to understand the cause of a child's anxiety and hostility is contrary to the experience of many therapists. Since a small child's emotional disturbances are, to a large extent, due to mishandling by parents, such parents are more likely to blame a child for his emotional unbalance than to accept their own role in causing such disturbances.

To illustrate how one mother was able to immediately benefit from one of his talks to parents, Dr. Moustakas cites a Mrs. A. In a personal interview following this lecture, the author had advised this woman "to listen to (her daughter) Betty's feelings, accept them, and indicate that she understood them." The mother ran into some resistance in getting her daughter to talk about her own feelings; this then made the mother decide to talk to her own parents about her own long repressed feelings.

"I took them (the parents) into the kitchen and closed all the doors and told them to sit down. I think it was the hardest thing I ever did. They looked at me in a puzzled way and wondered what in the world it was all about. After two minutes silence while I was struggling to hold onto myself, I finally said the words: 'I want you to know that there were

many times in my life when I hated you both. I couldn't say it then, but you said many things to me and did many things to me that really hurt me, and I hated you for it.' "

This woman then heard from her parents, for the first time, how they had also hated her. After each had admitted such feelings, the mother and her parents cried together, and she concludes, "We knew that we really loved each other." In writing this to Dr. Moustakas, she added, "You don't know how wonderful that made me feel. . . . I seemed to be a different person. I began to see many attitudes in Betty that I never knew existed."

Excerpts from this case have been quoted, since Dr. Moustakas considers it an example of the successful application of his child-centered philosophy. To this reviewer, however, it shows, rather, the limitations of the Rogerian technique. For to assume that a single episode, in which a lifetime of repressed hostility was expressed by this mother against her own parents, would be able to transform her entire relation, first to her parents and then to her child, is just a little too simple to be convincing.

Dr. Moustakas has wisely emphasized that his approach is "not mainly concerned with techniques and skills but rather with the kind of relationship which enables children to grow emotionally and to gain faith in themselves as feeling individuals." Playing out their problems in the permissive and accepting environment which the author describes may work well with normal and slightly disturbed nursery school children but rarely with those who are more severely disturbed.

New York City

MARGARET NAUMBURG

THE GROWING FAMILY, A GUIDE FOR PARENTS. Edited by Maxwell S. Stewart. New York, Harper and Brothers, 1955. 264 p.

This book is made up of ten popular pamphlets published by the Public Affairs Committee. Each pamphlet was designed for a particular public, and apparently it is the thought of the publishers that they now have a sequence of these pamphlets and can put them together in book form and thus have a useful tool. The result is a fairly successful try, but there are some hurdles in such an attempt.

The style in pamphlet writing is to hurry and get it said because one has only 48 pages! The style in book writing is more leisurely. An author does not hesitate to take time for examples and illustrations and thus rest the reader. In the present volume the pace never lets up. Everything is generalized. There is little time for the specific instance.

By and large, as this reviewer knows the literature, the material seems accurate, and it is well written. There is only an occasional

statement which is inaccurate or a conclusion which seems reached too hastily. A good analogy is that of riding in an airliner. You go along smoothly and all of a sudden you hit a bump in the air. The plane straightens out after a moment and soon you forget there was ever any roughness, and it was never very important.

There is some satisfaction in seeing several writers adopt very much the same point of view. In fact, in reading this material one finds that we are arriving at a sort of an eclectic approach to child care and training. The writers of this material are from different professional backgrounds, and yet they seem to approach their assignments with very similar principles and methods.

The book is made up of chapters geared to ages—infancy, early childhood, later childhood, adolescence. And then certain special topics are introduced—sex education, discipline, entertainment, and family living. It is a good arrangement, but one wonders whether a wiser plan might have been to continue the chronological sequence and have chapters on the college-vocational training age, entry into the world of work, maturity, and the period of decline.

I am sure the editor has done an excellent job of deleting and relating the materials, although this reviewer did not go back and make comparisons, paragraph by paragraph, with the original pamphlets. In spite of good editing, however, the amount of duplication of topics is considerable, and is so integrated into the material that no editor could eliminate it. However, this may not be a bad thing because we know that repetition usually enhances learning.

One wonders for whom the book was designed. It is not a text; it is not a reference book. It was not planned for parents of children of a particular age group. We feel it is especially suitable for study groups and "program" people. It will be helpful to those who are endeavoring to get a picture of child development from the pre-natal through the adolescent period, with the emphasis on young children. It would seem especially useful for discussion groups.

Great differences in style of writing occur, and this gives a certain charm to the book.

LOYD ROWLAND

Louisiana Society for Mental Health

NEW DIRECTIONS IN SOCIAL WORK. Edited by Cora Kasius. New York, Harper and Brothers, 1954. 258 p.

This volume was compiled as a tribute, by fourteen of his colleagues, to Philip Klein, "social worker, educator, and scholar" who throughout his career has given direction to the development of the theory and practice of social work. The various articles by outstanding educators, administrators, and thinkers in the field identify the significant

aspects of a profession still in the process of defining itself, but at a point of maturity where it can critically examine and question what it is doing and why.

Almost at the beginning a leader in the field asks, without providing the answer, "What is social work?" Throughout there is a reaching out for a specialized body of knowledge, principles, and concepts that are peculiar to this field, that distinguish it from the social sciences, psychiatry, and other fields from which much of its knowledge and skills stem. The need of formulations that are validly derived from experience and practice is reiterated. The writers are preoccupied with the evolving character of what should be transmitted in professional education or of what can be applied to social problems in other countries. Some of the myths, assumptions, and contradictions that color practice are subjected to an overhauling that is no less trenchant because of its wit.

Nonetheless, an underpinning of basic conviction emerges from this appraisal of changing, sometimes uncertain or ineffective efforts to help people. Social work does have a specific area of competence in providing services to help people with social problems. It has grown out of a belief that each individual can and should have a good life. It shares with other fields concern about people and their well-being, but it has particularly taken on the task of seeing to it that the needs of individuals are being adequately met. It has acted on what it has learned from working with people: what they are like, what they need, and what happens when they lack. It has considered the individual as a whole and in relation to his family, to his social group, and to an environment which may fail to provide what he needs to do those things that are expected of him. It deals with social problems that result from failures and inadequacies in meeting the individual's needs through the usual provisions or existing social institutions for doing so. It recognizes a multiplicity of causes that may lie both in the deficiencies of the provisions and in some incapacitation of the individual for using them.

The writers discuss the remedies provided by social work that have ranged from pioneer reform movements to correct, modify, or supplement the social environment or social institutions to techniques for the treatment and "adjustment" of the individual to his circumstances (sometimes referred to as "a less expensive form of psychiatry"). They point up the responsibility which has been increasingly assumed by government in its role of promoting the general welfare through social insurance and public assistance programs. The problems of financing both public and voluntary services are related to the low priority given to human needs and to lack of understanding of the value of social services that are preventive and rehabilitative.

Little attention is given to the professional skills which have been developed to help individuals through case work or group work methods and which are the main subject of current professional social work literature; but the obligation to interpret social needs, to participate in social action and community organization is underscored.

The new direction for social work is suggested: one that will lead the field to its own place and particular competence, in relation to other disciplines, where it can help in bringing about those conditions that make it possible for each person to have a better life, and can enable those individuals who by themselves cannot do so to develop, use, and enjoy their potentialities. The serious student will find the guideposts in this scholarly analysis of the objectives, methodology, and achievements of the field.

ZITHA R. TURITZ

Child Welfare League of America

MENTAL HEALTH AND MENTAL DISORDER: A SOCIOLOGICAL APPROACH.

Edited by Arnold M. Rose. New York, W. W. Norton, 1955.
626 p.

The Society for the Study of Social Problems seeks to "stimulate the application of scientific method and theory to the study of vital social problems, encourage problem-centered social research, and foster cooperative relations among persons and organizations engaged in the application of scientific sociological findings to the formulation of social policies." The society holds an annual meeting at the time of the American Sociological Society conference in September and a second meeting in February with the Society for the Psychological Study of Social Issues, an affiliate of the American Psychological Association.

When the Society for the Study of Social Problems came into being in 1951, the new organization selected Dr. Arnold M. Rose of the University of Minnesota as the first chairman of its editorial and publications committee. The plans for this book were laid at that time.

The appearance of the volume symbolizes the growing interest of sociologists, social psychologists, and social anthropologists in studying problems related to mental health and mental disorder. It also reflects the growing awareness on the part of psychiatrists and psychologists that the cultural and interpersonal factors are an important part of any analysis of causation, prevention, or rehabilitation. In fact, it signals the rapid coming of age of the new field, "social psychiatry."

Concerning the impressive array of contributors, the editor says, "While most of the authors have had their primary training as

sociologists, several are psychiatrists, psychologists, and anthropologists. In this truly interdisciplinary field, the formal educational background of an investigator is of less importance than the scope and quality of his contribution. To further this point of view we shall not make invidious distinctions by labeling our authors as to discipline or by designating them as having the degree of Ph.D., M.D., or M.S." (Preface, xiii and xiv) One-fourth of the selections are published for the first time in this volume. The others have been taken from various sources.

Appropriately, the volume is dedicated to Ernest W. Burgess, first president of the Society for the Study of Social Problems and himself a long-time student of social factors in personality development and in problems of the family.

Section I of *Mental Health and Mental Disorder* gives Dr. Burgess and three other authors an opportunity to define "problems of social psychiatry" and to state their general views in what the editor calls a "theoretical overview." Succeeding sections are concerned with social characteristics of the mentally disordered, the community setting, and social aspects of specific disorders, and concludes with three sections which cover a variety of marginal problems ranging from alcoholism to public attitudes toward mental illness and "mental hygiene and the class structure."

As is true of most symposia the volume dips into many fields. To some readers this will be confusing. After touching for only thirteen pages on such a complicated topic as "Social Stratification and Psychic Disorders" the book shifts rapidly to a brief look at occupation as it relates to mental disorders and ethnic variations. These brief glimpses do, however, introduce the new student of mental hygiene and also the narrowly specialized scholar to the present leaders in the broad field of social psychiatry, to the concepts and research methods they use, and to the trend of their findings.

The essays are irregular, not in quality but in type. Some are brilliant, general statements of trends and theories. Other chapters include detailed reports of studies dwelling upon such questions as whether persons who sleep with their mothers during infancy are more or less likely to develop personality difficulties later on, suicide rates in rural Michigan, and "becoming a marihuana user." The reader must choose for himself which essays introduce him best to the field. He can be certain that the volume gives him a nodding acquaintance with the principal research approaches and the most authoritative spokesmen of them.

The volume is carefully edited, well-printed, and the documentation refers the reader to the larger studies.

ROBERT L. SUTHERLAND

Hogg Foundation for Mental Hygiene

TRUANTS FROM LIFE. By Bruno Bettelheim. Glencoe, Ill., Free Press, 1955. 511 p.

This book is a classic in the ever-widening field of institutional treatment of the disturbed child. It gives to the profession the very essence of the Orthogenic School. The description and documentation of almost superhuman effort in helping a generally untreatable group of children is as forthright an account of success and failure as the literature on this subject has offered since *Wayward Youth*. This is practical, on-the-job research at its most sophisticated level, a work from which practitioners in the field can draw endlessly and each time find the threshold of renewed effort and inspiration.

In its quest to explore the limits of institutional treatment the school selects the very sick child, the one where all other efforts and therapies have failed. That its methods have led to rather phenomenal success in many of its children should not, however, lead others to blind assumptions or foolhardy imitation.

There has, in fact, been far too much of the panacea-type development in this field and the book should provide a sobering outlook to those who seek similar gains but are not prepared to invest the necessary measure of funds and human energy. The four remarkably detailed and live case histories set the highest standard of scientific inquiry and personal demand upon those workers who under Bruno Bettelheim dedicated themselves to these children. Having read this book one gains a new perspective and caution regarding the so-called "successful treatment" of the disturbed child. It establishes the fact dramatically that for such severely disorganized children there is no shortcut back to the world of reality and useful social living.

It should help many institutions who are working with the less seriously disturbed child to evaluate the effectiveness of their own programs and personnel. One can see how many well-intentioned programs with insufficient resources can be just short of the critical strength needed, and may therefore be entirely wasted or do more harm than good.

By implication, the case histories of these children reinforce our conviction of the need for earlier and more comprehensive diagnosis. Many of the children at the Orthogenic School are the residue of previous agency failures, a point on which the author is rather gracious in his discussion. Cases which had been known to a variety of agencies for a period of several years prior to admission to the school lead inevitably to the conclusion that a complete family diagnosis of sufficient scope had never been made. For in unraveling the child's early life one can see that a better analysis of the total family situation would have led to a more inclusive treatment plan and more accurate differential diagnosis of both parents and children.

It is a common failure of our highly specialized services to families and children that they lack the skills and perspective for total diagnosis, that treatment is often individual and symptom-centered. When the child can finally no longer be tolerated in a normal environment, his only resource for help may be the institution. Could this have been prevented by those agencies and therapists who first knew the child, and should have known the total family, several years earlier? Can we so organize our specialized skills and agencies to synthesize our efforts more effectively for an earlier arrest of such problems? These are important questions to which this book does not address itself, for this was not its purpose. But for many who read it there cannot be satisfaction alone in the good job done at this late and costly stage.

The reality of the matter is that the Orthogenic School's investment begins at the end of personal disaster. In addition to the benefits gained by a few children, the school's greatest contribution may well be its illumination of the total life complex which harbors the seeds of mental illness. Can we learn from these histories and the many evidences of early family disorganization how to deal with reactions and interactions in the family constellation more successfully? For as long as we are not equipped to do so and children continue to move from one agency to another as problems become more severe, we will need a service of last resort. In a very practical way we know that there can never be enough orthogenic schools to meet the need. The majority of such children will continue to flow into hospitals and correctional institutions. Also these children might have been helped with a lesser per capita investment earlier, and available resources spread to serve more children.

This book, then, makes two major contributions to the field: first, it is an unusually fine account of the creative treatment of severely disturbed children; second (though not expressly so intended by the author), the book poses a basic challenge to all agencies in the adjustment field to examine the effectiveness of their methods, the incompleteness of too highly specialized effort, and the possible development of an earlier, more comprehensive attack upon the evidence of interrelated factors in family breakdown.

FRANK T. GREIVING

New York City

CULTURE AND MENTAL DISORDERS. By Joseph W. Eaton and Robert J. Weil. Glencoe, Ill., Free Press, 1955. 254 p.

This fine book studies the Hutterites, members of an intriguing religious sect who live in the American-Canadian West and carry

on an Anabaptist and economically communal tradition more than four centuries old. They live in small self-contained farm colonies. These colonies are noncompetitive, oriented toward stability and social order, providing every member with a high level of economic security from birth to death.

This work shows very clearly how in these people the adaptation problems which constitute what we call normal and abnormal behavior are very much mitigated, leading to a great reduction of emotional and mental disorders. This group is like a small laboratory, where the psychologist, the psychiatrist, and the anthropologist are able to study experimentally man living in a quite different setting than that of modern western civilization.

The conclusions are definite, concerning the great influence of culture in producing and shaping man's behavior, either in the form we call normal or in the one we call abnormal. It also shows how important it is for psychiatry to integrate in its body of knowledge sociology and the study of interpersonal relations. On the other hand, it shows how no culture can provide immunity from mental disorders. We also conclude that man needs to be in close contact with his fellow-men in order to live a happy and productive life. It is equally paramount to have an ideal, religious or any other kind.

In many ways the book leads to conclusions quite similar to those of Erich Fromm, a "cultural psychoanalyst," who demonstrated that man from the Middle Ages to modern times, while trying to find his freedom, often becomes bewildered and anxious to the point of choosing to submit himself unconditionally to dictatorial governments.

The analyses of psychoses among the Hutterites brings support to the idea of the need to review the Kraepelin conception, which still exists in psychiatry. For instance, it seems that depressive and manic states among the Hutterites are never alternated, and this speaks against what the authors call the "forced marriage" between both states in the so-called "manic-depressive psychoses." Actually, the authors' observations indicate that many depressive states should be considered apart from that syndrome.

Regarding schizophrenia, their conclusion seems to be that sociological factors have only limited influence on the manifestation of this disease, although in this group symptoms were rarely extreme either in their severity or in the displaying of antisocial tendencies.

The Hutterites, by their way of living, seem to be protected from exposure to drugs, unlimited amounts of alcohol, and syphilis, so there is a relative rareness of "organic psychoses."

Among the Hutterites old people enjoy high prestige and com-

munal support, and these factors seem to prevent the extreme social deterioration which sometimes accompanies aging.

Many of the more interesting conclusions deal with psychoneurosis. The authors think the Hutterites react to most stresses with signs of depression rather than with anxiety symptoms, obsessive or paranoid tendencies, as neurotic patients often do in the American culture.

So this study seems to indicate that cultural values and social relations are significant factors in the etiology of psychoneuroses and that in psychoses they are not so important. This seems to favor the theory that neuroses and psychoses are often different processes, in opposition to the theory which claims that they are different grades of the same disease.

The Hutterite people do not rear their children in an environment of permissiveness, which they think to be unwise. Impulsive behavior, masturbation, and aggression are energetically repressed. Nevertheless, parents demonstrate great affection for their children.

Among the Hutterites there seem to be very few personality disorders (people who execute antisocial acts in a repetitive way). The same is observed regarding crimes.

As to treatment, the psychological side is completely disregarded. One contributing factor for this is the high cost of psychotherapy and another the fact that they regard doctors mainly as "doers."

The outlook for mental diseases is generally optimistic. Some psychotic and sociopathic persons are considered "bad" cases. The Hutterites usually demonstrate a great deal of sympathy for the depressed, the defective, and the epileptic.

Finally, the authors ask whether or not the people are healthy. They bring into consideration that health is a value and not a scientific judgment. So it is very difficult to make a statement about this point. Nevertheless, the Hutterites' social system is, according to the writers' opinion, quite healthy.

A. C. PACHECO E SILVA

Clinica Psiquiatrica
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GOOD HEALTH FOR YOU, YOUR FAMILY AND YOUR COMMUNITY. By Nelson S. Walke, Ph.D., Nathan Doscher, LL.B., Ph.D., and Glenna Garratt Caddy, M.D. New York, McGraw-Hill, 1955. 415 p.

Judging from the preface, the authors of this book sought to emphasize that although the factors which contribute to health and healthy living can be divided into major categories, these categories are thoroughly interdependent. They therefore sought to examine these many different health factors and their interrelationships with

other significant influences in order to arrive at an accurate concept of total healthful living. For this reason the authors discussed, in a surprisingly condensed manner, elements of genetics, medicine, law, biometry, demography, epidemiology, dentistry, public health, disaster control, anatomy, physiology, recreation, family life preparation, to mention only a few, and classified them under three main headings: the family, the community, and the individual.

To accomplish this task of demonstrating the multi-ordinality of health, the authors adopted the clipped, concise, authoritative, almost topical style of a textbook. This enabled them to furnish an encyclopedic review of respected opinion and accepted facts under a multitudinous number of subject headings in the least amount of space. For example, only two pages were devoted to the subject of juvenile delinquency, three-fourths of one of these being used for a statistical table.

Some professionals in the field of health and physical education might find the content too elementary; the style, though lucid, necessarily dogmatic; and the language too filled with unmodified statements for their tastes. But they would probably admit that this book can fill a real need among certain groups of intelligent citizens. There is also a possibility that some non-professional readers might find the integration of varied health factors difficult to achieve because of the many subjects discussed.

Nevertheless, the book can be readily recommended for use as a textbook in courses on health in secondary schools and colleges, in adult education, and in citizens discussion groups. It could also be successfully employed in schools of nursing and social work, and in introductory courses on family health in medical schools. The excellent index and subject structuring of the contents, together with listing of pertinent facts and statistics in the text, and an adequate bibliography at the end of each chapter also extend its usefulness as a book of ready reference for the busy teacher or lecturer who is frequently confronted with the need for a source of definitive opinions and facts on the many aspects of health to refresh his basic knowledge in the field.

A major feature of this book, to be found at the end of every one of its twenty-three chapters, is the listing of a number of questions under the heading of "Problems." These questions, of the type customarily asked in examinations, deal with the content of the previous chapter. They have been carefully prepared to provoke honest thought and personal effort, and cannot be easily answered without really knowing the subject. They lend themselves readily for "homework" or for group discussions.

The authors have made a painstaking effort to assemble and syn-

thesize in but 400 pages a vast compendium of up-to-date scientific material concerning the total health of the individual, family, and community, utilizing the many contributions of related sciences in a condensed but very lucid style and easily understood vocabulary.

Geoffrey W. Esty, M.D.

New Jersey State Department of Health

THE LIFE AND WORKS OF SIGMUND FREUD. 1901-1919: Years of Maturity. Vol. 2. By Ernest Jones, M.D. New York, Basic Books, 1955. 512 p.

The second volume of Ernest Jones' biography of Freud is magnificent. In some respects the account of the years of maturity surpasses that of the formative years. The author's clear, concise writing is particularly evident in part 2 of the volume, in which he succinctly and brilliantly abstracts and evaluates all of Freud's writings published between 1901 and 1919.

In his effort to make his work the definitive biography of the master, Jones at times, in the first part of the volume, goes into minutiae that are unnecessary. He supplies the names of the hotels at which Freud stayed during his many short excursions and several times even details what he paid for his rooms.

There are many illuminating observations about the early leaders in the psychoanalytic movement and much material that is of great historical importance, particularly in the relationship of Freud and Jung. It is interesting, in the light of the increasing requirements for personal analysis of those who are today in training, to learn that such leaders as Abraham and Ferenczi had little or no personal analysis. Jones, in retrospect, seems to feel that this deficiency was in large part responsible for the defections of Jung, Adler, Stekel, and others, and for the bitter animosity that they displayed toward Freud. Of this, the reviewer must be somewhat skeptical in light of some of the internecine activities that have taken place in some of our American psychoanalytic societies, by men who had had prolonged analysis.

Freud emerges from this volume as a giant, but remains an enigma. In many respects he has more of the makeup of the artist than the scientist. Few individuals could have had more complex personalities; his character was full of paradoxes. Despite his lust for truth and his independence of commonly accepted beliefs, he clung to superstition, such as the one that he was to die in February, 1918. He harbored prejudices against the Swiss and against Americans and America. At the outbreak of World War I, he wholeheartedly accepted the justice of the cause of Germany and its allies. He opposed the restrictions that western culture has placed on sexual

expression outside of marriage, yet few men have led such a monogamistic life. He had little vanity and never had a wardrobe of more than three suits, but he had a barber come daily to his home to trim his beard and he hated to be considered old. Despite his uncanny penetration into the deepest structures of his patients' personalities, Jones maintains, apparently with justification, that Freud was not an astute judge of people. The volume ends with the author's bold attempt to find the secret of Freud's genius. He analyzes his personality and the early influences that molded him. This reviewer finds the author's conclusions quite unconvincing.

With his great moral courage, his compelling sense of fairness, and his intellectual daring, Freud stands out among contemporaries like one of the great biblical prophets of old.

The psychiatric world awaits Jones' final volume with intense eagerness.

MANFRED S. GUTTMACHER, M.D.

Baltimore, Md.

MATERNAL EMOTIONS.. By Niles Newton, Ph.D. New York, Harper & Brothers, 1955. 140 p.

To live with our human emotions is both puzzling and often difficult. To attempt to scrutinize any segment of such emotions with scientific objectivity and the application of statistical techniques takes vision, skill, and courage. Niles Newton deserves recognition for all of these. In addition she should win acclaim from all thoughtful members of the fairer sex for her dedication to "helping women to have better health and more satisfying lives."

Dr. Newton's contribution toward this goal is made by questioning systematically in the rooming-in wards of the Jefferson Hospital a group of 123 mothers of newborn babies. Eighty-four percent of these mothers were Negroes. The interviews were conducted personally by Dr. Newton, who attempted to discover how these women felt toward vital areas of their living: menstruation, pregnancy, childbirth, breast feeding, rooming-in care of their baby, satisfaction in woman's role in life, wish to be a man, and, in a few instances, attitudes toward sexual intercourse. Feelings of satisfaction or dissatisfaction in each of these categories were compared to information on the medical record concerning the individual mother's health, the ease or difficulty of her menses, the pregnancy, the birth, and the breast feeding of the child. The results were tested for statistical significance and include a group of specific and suggestive findings. In addition, the author reviewed and included in her discussion a large variety of ideas and facts from related experiments and reports.

In the concluding pages of the book all of this material is helpfully

summarized (p. 102). "These studies almost all," states Dr. Newton, "tend to show the same general thing—that woman's feelings and emotions toward her wider sexual role are often related to her behavior, her attitudes, and her health. In general, but not always, positive feelings are more likely to be associated with good health and well-being, whereas negative feelings are more likely to be associated with poor health and dissatisfaction."

If these findings are valid for women in general, they merit the gravest consideration by parents and educators. Does our present training at home and in school tend to foster closer identification on the part of our girls and young women with their biological functions? Does it foster greater acceptance of the creative and important aspects of their role as wives and mothers, rather than as competitors with men for jobs? Does it foster confidence and joyfulness in themselves as women rather than abet them in imitating the attitudes and activities of men? Do we by these and other means aid in decreasing conflicting values for women and thus increase their mental health?

Dr. Newton makes no claim to final knowledge in her study and assiduously defines the group with whom she worked as not typical. It is obvious that one cannot with reliability apply the results of a study conducted primarily with Negroes from a low economic classification to white women of college education. Another point which apparently the author did not take into consideration is whether a particular woman's attitude toward the questions studied may vary from one pregnancy to another. In my own clinical and research experience in the field of marriage counseling, we have learned that the way a woman feels about her marriage may very definitely alter the way in which she sees her husband. If she feels happy and contented in her marriage and in her love for her husband, the expectation would be that she would be much more apt to be happy and contented in relation to planning for a child. There is also the possibility that a woman's attitude toward her first pregnancy might be quite different than her attitude toward a seventh. One could wish that Dr. Newton had asked these women what their feeling was about this pregnancy—in other words, was it a wanted or unwanted condition? We have known of a dramatic shift in a woman's health in connection with pain at menstruation, comfort during pregnancy, attitudes toward birth, etc., when a woman is living with a man who loves her and whom she loves as compared to an experience when she was married to someone whom she cordially disliked. In this connection we might note in passing that 28 of the mothers studied were unmarried or separated. It does not seem illogical to expect that such mothers might at that time harbor fairly strong feelings of

resentment toward men and toward themselves as women. It would be interesting to be able to break down the results in connection with these differences in the group. I also find myself wondering whether a woman's attitude toward menopause would not fit into the same frame of reference of health as the other intimate items studied. In other words, positive feelings toward this condition would be more likely to be associated with good health and well-being, negative feelings with poor health and dissatisfaction.

Another small point deals with Dr. Newton's statement that women have lost status rather than gained it with the coming of the industrial revolution. Does the author not refer to loss of status by *married* women? It seems to me that this might be argued, but that single women have definitely gained in their capacity for independence and in their status as wage-earners.

One of the easiest techniques for a reviewer of a book is to ask questions and to wish that the author had extended her study to a wider universe. In this instance, as Dr. Newton herself intimates, one of the most important reactions that her excellent research can accomplish is to stimulate more and yet more questions and point the road to their solution. This reviewer at least hopes that Dr. Newton herself will continue her leadership in exploring the many unknowns and in helping to find the answers.

EMILY H. MUDD, PH.D.

Marriage Council of Philadelphia

HUMAN RELATIONS IN ACTION. By H. Edmund Bullis, A.B., M.E., and Cordelia W. Kelly, R.N., B.S. New York, G. P. Putnam's Sons, 1954. 86 p.

Human Relations in Action is a recent addition to the handbooks prepared for the use of administrators, supervisors, and others who deal with groups of workers. It is a comparatively small volume, and the subject matter is presented in fifteen short chapters.

The material is a practical presentation of mental hygiene principles applicable to a wide variety of students and employees. The importance of understanding the nature and value of emotions is stressed, and the explanatory text is interesting and convincing.

Shop foremen, supervisors of workers in industry, store operators, and those directing transportation workers, as well as hospital administrators and community health workers, may apply the teachings presented.

Nurse instructors will find it of value in presenting mental health concepts to student nurses and graduate staff. Those responsible for in-service education of ward personnel in mental and general hospitals will find it a valuable source of illustrative and explanatory subject

matter. Case studies are presented in the various chapters, and discussion or dissection of the problem, leading to suggested solutions, provide interest.

Chapters one through four explain in easily comprehended terms the emotional forces underlying our behavior and the motives for our actions. The acceptance of one's self, with recognition and acceptance of limitations and possibilities, is given first place and sets the tone for wholesome reflection established in the text.

The enjoyment provided by emotions and their influence on an individual's acceptability as a companion, friend, or fellow-worker are presented with suitable stress. "Learning To Be Likable" and "Personality Assets and Liabilities" are chapter titles that will attract readers. "Leadership" and "Making and Keeping Friends" also are of absorbing interest, and the counsel provided is applicable.

Direct advice is provided concerning relaxation and the value of good morale and of meeting emotional and other problems honestly and without subterfuge. These delicate subjects are treated straightforwardly.

Each chapter includes questions for discussion or thought-provoking items.

This unpretentious, easily read handbook provides intellectual stimulation of value out of proportion to its size. The authors are well-versed in their subject and have presented it to appeal to a wide variety of readers.

An index would increase the book's usefulness.

MARY E. CORCORAN

Harrisburg, Pa.

NOTES AND COMMENTS

TURNING POINT REACHED IN FIGHT AGAINST MENTAL ILLNESS

The turning point in the nation's drive against mental illness was very probably reached in 1955, according to F. Barry Ryan, Jr., president of the National Association for Mental Health.

Summarizing important events of last year in the NAMH annual report, released April 22, Mr. Ryan described 1955 as "a year of exceptional progress." But despite gains, he warned, the nation's #1 health problem will not be conquered until a Citizens' Army against Mental Illness is mobilized, similar to the citizens' movements which have helped stem other serious illnesses.

NAMH, consisting of 500 local and state mental health associations, is now in the process of recruiting such an army, Mr. Ryan emphasized. He pointed out that public education through newspapers, magazines, TV and radio has made the public better informed on mental illness than ever before and "ready for the first time to give mass support to science's efforts to combat mental illness."

Noting other gains, Mr. Ryan reported:

Last year 38 states increased their appropriations for the care and treatment of mental patients, primarily to obtain sorely needed personnel.

Congress created a Joint Commission on Mental Illness—representing 18 major national organizations including NAMH—and authorized a \$1,250,000 fund for a three-year investigation into all aspects of mental illness.

As deficits, Mr. Ryan noted that the majority of the nation's 750,000 mental patients still receive little or no treatment, many states still jail patients before admitting them to mental hospitals, and the increased rate of discharges from hospitals as a result of drug therapy intensifies the problem of inadequate rehabilitation facilities and after-care services.

Reporting considerable organization growth since 1950, Mr. Ryan said NAMH now consists of 35 state and 470 local mental health associations, compared to 18 state and 150 local groups in 1950.

NATIONWIDE STUDY GETS UNDERWAY

The Public Health Service has approved the application of the Joint Commission on Mental Illness and Health for grant support of a nationwide study of the human and economic problems of mental illness and an initial grant of \$250,000 has been awarded for support of the project for the first year. Approval of the grant follows favor-

able recommendation of the application by the National Mental Health Advisory Council.

The award carries out the mandate of the Mental Health Study Act (Public Law 182) authorizing the Surgeon General of the Public Health Service to award qualified non-governmental organizations a total of \$1,250,000 in grant allotments over a period of three years to undertake an "analysis and re-evaluation of the human and economic problems of mental illness." The legislation, passed by Congress last year without a dissenting vote, requires recipients to file annual reports and a final report with the Congress, the Surgeon General, and the State Governors.

Dr. Jack R. Ewalt, clinical professor of psychiatry at Harvard and also commissioner of the Massachusetts State Department of Mental Health, is directing the study from headquarters in Boston. Organization of the survey staff has been progressing.

The Joint Commission of Mental Illness and Health was incorporated in the District of Columbia in August 1955. Its membership includes representatives of the American Medical Association, American Psychiatric Association, and other organizations and agencies with a major interest in the social, legal, scientific, clinical, and psychological aspects of mental illness. Many other organizations with related interests will also be asked to participate in the work of the Commission. Of the fifteen members on its board of trustees, five persons are designated by the American Medical Association, five by the American Psychiatric Association, and five by the following organizational members: American Association of Psychiatric Social Workers; American Hospital Association; American Psychological Association; Coordinating Council of American Nurses' Association and National League for Nursing; and the National Education Association.

Dr. Kenneth E. Appel, professor of psychiatry at the University of Pennsylvania School of Medicine, is president of the Joint Commission on Mental Illness and Health, and Dr. Leo H. Bartemeier, chairman of the Council on Mental Health of the American Medical Association, is chairman of the Commission's board of trustees.

It was Dr. Appel, as president of the American Psychiatric Association three years ago, who first called for what he described as a "Flexner-type" study of present methods and practices for dealing with the mentally ill which would lead to a fundamentally new attack on the problem. The famed Flexner Report of 1910 revealed the deficiencies of medical training of that era and led eventually to the high levels of medical education today. Dr. Appel's call was vigorously seconded by the Council on Mental Health of the American Medical Association, and together the A.P.A. and the A.M.A. invited

many other organizations to consider the proposal. This was the start of what later emerged as the Joint Commission on Mental Illness and Health.

Dr. Bartemeier recently declared that the Mental Health Study Act of 1955 offers the chance of a lifetime to develop guideposts to point the way to a fundamentally new attack on this staggering problem. He emphasized that the Joint Commission is organized to insure that the intent of the Congress as stated in the Mental Health Study Act is carried out through an interdisciplinary approach to all aspects of the problems of mental illness and health in this country.

The organizational members of the Joint Commission on Mental Illness and Health are the American Medical Association, American Psychiatric Association, American Psychological Association, American Public Health Association, American Association of Psychiatric Social Workers, American Hospital Association, American Bar Association, American Association of Psychiatric Clinics for Children, American Association on Mental Deficiency, American Occupational Therapy Association, American Psychoanalytic Association, Coordinating Council of American Nurses' Association and National League for Nursing, Council of State Governments, Central Inspection Board of American Psychiatric Association, U. S. Children's Bureau, Joint Commission on Accreditation of Hospitals, National Education Association, National Rehabilitation Association, National Institute of Mental Health, National Association for Mental Health, National Mental Health Committee, Office of Vocational Rehabilitation, Social Science Research Council, Veterans Administration, and U. S. Department of Defense.

EDUCATIONAL CAMPAIGN WINS SUPPORT OF NATION

Millions of Americans in thousands of communities turned the eighth annual observance of National Mental Health Week, April 29 to May 5, into a coast-to-coast rally on behalf of the mentally ill. Simultaneously, the nation's 500 mental health associations launched a month-long membership and fund-raising campaign, the biggest ever conducted to fight mental illness.

Both Mental Health Week and the Mental Health Campaign were backed up by a barrage of TV and radio announcements, newspaper and magazine publicity and billboard advertising. Over 100 stations of the CBS-TV network led off the two events April 29 with an hour-long rebroadcast of "Out of Darkness," outstanding television film produced by CBS Public Affairs in consultation with the National Association for Mental Health and the American Psychiatric Association.

At the close of the telecast, sponsored by Wyeth Laboratories, Vice-President Richard M. Nixon called on the country to support the

NAMH in its efforts to help those suffering the tragedy of mental illness. With Miss Martha Rountree, editor and TV producer, as national campaign chairman, members of the state and local mental health associations set out to enlist their neighbors and friends in a Citizens' Crusade Against Mental Illness.

During Mental Health Week, the nation engaged in a sweeping educational campaign. Citizens sponsored hundreds of public meetings, heard Mental Health Week proclamations by scores of governors, mayors and city councils, and read thousands of newspaper features and other publicity.

They toured mental hospitals, honored 88 psychiatric aides for outstanding services to mental patients, attended lectures by psychiatrists and others who work with the mentally ill, saw movies on mental illness and health, heard special sermons on Mental Health Sunday, inspected special library exhibits of publications on mental and emotional problems, and heard hundreds of celebrities appeal on TV and radio and in newsreels for help for the mentally ill.

Dramatic events created acute interest in the problems of the mental patient. In Maryland, Miss Dora Myers, 71, came home after 18 years as a patient in Spring Grove State Hospital. Now, as Maryland's Mental Health Belle of 1956, she is working with community leaders to better the lot of the 750,000 men and women still living out their lives in crowded mental hospitals.

More than 50 senators endorsed a concurrent resolution—introduced by Sen. George A. Smathers of Florida—calling on Congress to encourage support of the Mental Health Campaign and Mental Health Week. In a speech to the Senate March 22 Senator Smathers said, "It is most important that the American people be aroused as never before to the threat of mental illness, and encouraged to organize in their communities in citizens mental health associations to combat mental illness in every way possible. They should be stimulated," he added, "to contribute financially to the work of the National Association for Mental Health, which, nationally and through its local and state mental health associations, has been leading the fight against mental illness."

In Delaware, 81 state-wide organizations joined under the leadership of U. S. Senator John J. Williams, honorary state chairman of Mental Health Week, in co-sponsoring seven public meetings, each highlighting a different aspect of mental health.

In Teaneck, N. J., 125 high school students crowded into an auditorium to be briefed on their responsibilities in their county's campaign against mental illness. "This is the first time young people have been asked to carry the ball for a community-wide campaign," the *Paterson News* reported, "and even though assistance will be

given by the Teaneck Retired Men's Club and the Junior Chamber of Commerce, the drive's success will be a demonstration of what teen-agers really can do when they are given a chance."

In San Francisco, three Hollywood stars and 32 civic and psychiatric organizations called public attention to Mental Health Week in a series of daily luncheons. The stars—comedian Jack Haley, singer Barbara Whiting and Western actor Hugh O'Brian (Wyatt Earp)—are members of the Thaliens, movie colony organization whose first big public-service project is publicizing the Mental Health Campaign.

In Washington, D. C., dance group patients of the Dorothea Lynde Dix recreation and intensive treatment center of famed St. Elizabeths Hospital produced the Skitzofollies of 1956, a revue that included such divertissements as a Rorschach ballet.

In Chicago, more than 1,300 mental health workers, leaders of both houses of the Illinois legislature, representatives of state-wide civic groups and private citizens attended the eighth annual Illinois Mental Health Dinner.

In New York City, the mental health associations of five boroughs pledged to Mayor Robert F. Wagner "their energy, thought and funds to the prevention and relief of mental illness" and certified that they will "press forward in education, research and community service for the benefit of the 8,000,000 people who live and work here."

And in Milwaukee, a revue produced by high school seniors revealed "the hopes, fears and dreams of young people as they seek to find themselves through self-expression." *The Milwaukee Sentinel* called the show "a fitting climax" to a long list of activities in Mental Health Week.

PAY TRIBUTE TO DR. MARION E. KENWORTHY

Hundreds of leading psychiatrists, social work educators and practitioners, and prominent citizens paid tribute in New York City, May 7 to Dr. Marion E. Kenworthy, one of the nation's most renowned psychiatrists and a pioneer educator in psychiatry, social work, and mental health.

The annual Founder's Day celebration of the New York School of Social Work, Columbia University, marked Dr. Kenworthy's retirement in June as professor of psychiatry after 36 years of distinguished and dedicated service on the faculty. Kenneth D. Johnson, dean, announced that friends and admirers of Dr. Kenworthy are contributing sums sufficient to endow a \$400,000 Marion E. Kenworthy Professorial Chair in Psychiatry at the school.

Dr. William C. Menninger of the Menninger Foundation, Topeka,

Kansas, was the principal speaker at the ceremonies honoring Dr. Kenworthy.

On learning of Dr. Kenworthy's imminent retirement, President Eisenhower recently wrote her, in part: "Now—on the eve of your retirement from the New York School of Social Work—I want to assure you of my gratitude for your distinguished contribution to a great university and for your long and dedicated service to the welfare of our country.

"You, through many years, by your selfless labors, have moved men and women alike to a deeper realization of their responsibilities as Americans and a more effective discharge of them. With all those who have come to know and admire you as teacher and friend and leader, I join in congratulations on a great career and best wishes for the future."

Among the countless inspiring contributions Dr. Kenworthy has made in her career on behalf of the American public were her devoted war services. As a civilian during World War II, she helped to improve recruitment and selection procedures, win specialty status for psychiatric social workers in the armed forces, and modernize military psychiatry generally. Army Chief of Staff General George C. Marshall appointed her in 1944 to the then newly-created National Civilian Advisory Committee to the Women's Army Corps (WAC). During the Korean War, Assistant Secretary of Defense Anna M. Rosenberg organized the Defense Advisory Committee on Women in the Services, to which Dr. Kenworthy was appointed and on which she still serves.

A graduate of Tufts (she received her M.D. with honors in 1913), Dr. Kenworthy soon after became the first woman physician at Gardner (Mass.) State Colony for chronic mental patients. She simultaneously worked and studied at Boston Psychopathic Hospital with a brilliant constellation of psychiatrists. Among them were Karl A. Menninger, of the Menninger Clinic; Karl M. Bowman, of American Psychiatric Association, professor of psychiatry at the University of California and director of the Langley Porter Clinic in San Francisco; the late Frankwood E. Williams, of the National Association for Mental Health; the late Herman Adler, director of the Institute for Juvenile Research in Chicago; Harry C. Solomon, director of the Boston Psychopathic Hospital and professor of psychiatry at Harvard; and Lawson G. Lowrey, pioneer in child guidance work.

In 1921 Dr. Kenworthy first began to teach regular psychiatric courses at the New York School of Social Work, the first institution of its kind in the country. It was a decisive year for her. She had received a training analysis from Otto Rank—before his break with his mentor, Sigmund Freud—on his first visit to this country. Thence-

forward she practiced psychoanalysis (as a Freudian, not a Rankian), and her teaching stemmed from this dynamic orientation. When she retires, Dr. Kenworthy will have finished the longest continuous association as a psychiatrist on a social work school faculty in the annals of American psychiatry.

At the New York School, Dr. Kenworthy underscored and advanced four contemporary trends: (1) the study of the child for clues to the dynamics of human behavior; (2) the shift toward the preventive ideal in approaching problems of delinquency and emotional disturbance; (3) the development of the "teamwork approach," centering mainly around the psychiatrist, the psychologist, and the social worker in the study, diagnosis, and treatment of human behavior problems; (4) the training of social workers acclimated to this clinic team setting.

It is estimated that Dr. Kenworthy has taught more than 10,000 students, many of whom became leaders in their fields—deans and faculty members of social work schools, heads of welfare agencies, community executives. Students have come from across the nation to attend Dr. Kenworthy's classes.

Dean Johnson paid tribute to Dr. Kenworthy's brilliant career in observing: "Marion belongs to that immortal tribe of teachers whom students remember vividly throughout their lives. No one of our faculty has had a greater or more sustained impact on our students."

PTA RECOMMENDS CONTINUOUS HEALTH SUPERVISION

The National Congress of Parents and Teachers has adopted a policy supporting and encouraging continuous health supervision of children from birth through their school years, rather than a single appraisal when they enter school. Following recommendations adopted by the board of managers May 24, 1956, the Congress will recommend to local PTA groups a promotional and educational program that "will tend to bring children and their parents into effective contact with the health resources of the community."

Essential elements of continuous health supervision, they point out, include, among other factors, evaluations of the child's physical, mental, and emotional development, adjustment and deviations; consultation with parents on the management and prevention of behavior and personality problems, and on plans for treatment; and referral to appropriate services when necessary.

Meanwhile, the Welfare and Health Council of New York City has launched a study of the "great need for a coordinated mental health program for school-age children." Dr. Ray E. Trussell, chairman of the council's survey advisory committee, said the study is part of a three-year survey to determine the effectiveness of the city school

health service in placing children with health problems under care and in improving methods of referral for proper and timely treatment. The mental health study will focus on screening and detection through teacher observation and other techniques.

DRUGS HASTEN DISCHARGE OF LONG-TERM PATIENTS

Discharges of former chronically ill mental patients after treatment with tranquilizing drugs increased 36 percent at the Northampton (Mass.) Veterans Administration Hospital, according to a survey released in June. The hospital reported that 118 patients were discharged during the last six months of 1955, when extensive drug treatment was given, compared to 86 discharged during the last six months of 1954, when few patients received tranquilizing drugs (chlorpromazine and reserpine).

Among patients hospitalized five years or longer, the percentage of improved cases was higher for those treated by drugs than for those receiving other types of treatment, according to Dr. Lionel M. Ives, director of professional services at the hospital. Thirty-three long-term patients were discharged in the last half of 1955 compared to 19 the year before without benefit of drugs, a 77 percent increase.

Of 533 patients receiving various types of psychiatric treatment, 202 were treated with tranquilizing drugs. Of the 202, 76 percent showed improvement. The percentage of improvement in those treated with the tranquilizing drugs was considerably higher than among those given other types of psychiatric treatment. Many of those successfully treated with drugs had failed to improve under other types of treatment.

The other forms of psychiatric treatment studied were found effective to the following degrees: insulin, 59 percent; electric shock, 54 percent; lobotomy, 46 percent.

The group surveyed ranged in age from 18 to 69 years and had been hospitalized from one month to 30 years.

Where formerly these seriously ill long-term patients were hyperactive, destructive, and in need of restraint, after drug treatment their tensions were reduced and they expressed new interest in their surroundings, with a definite desire to be cured completely.

DR. ROCHE HONORED

Dr. Philip Q. Roche, Philadelphia psychiatrist, received the Isaac Ray Lectureship Award of the American Psychiatric Association at the APA's annual meeting in Chicago April 30-May 4. The award is given annually to a lawyer or psychiatrist for contributing importantly to better understanding between law and psychiatry.

As winner of the \$1000 award, Dr. Roche will deliver a series of

lectures on psychiatry and the law at the University of Michigan, under the joint sponsorship of the law and medical schools there. These will later be released in book form by Farrar, Straus & Cudahy, publishers.

Just prior to World War II, Dr. Roche, as chairman of a joint commission of the Philadelphia County Medical Society and the Philadelphia Bar Association, was largely responsible for the widely praised Pennsylvania plan for intramural training in penal psychiatry. Supported by the Commonwealth Fund, the plan provided fellowships for training physicians in penal psychiatry at Eastern State Penitentiary in Pennsylvania. It operated for two years but was discontinued when the war broke out.

Dr. Roche was chairman of the committee on forensic psychiatry of the Group for the Advancement of Psychiatry from 1948-1952, and has been a member of the APA committee on legal aspects of psychiatry since 1942. He has served on the Philadelphia Advisory Commission on Commitment, Detention and Release of Prisoners, and was a founding member of the Philadelphia Medical Legal Institute. His contributions to the literature include articles on the relation of syphilis to crime, masochistic motivation in criminal behavior, community control of sex offenders, sexual deviations, and many other topics. In 1952-1953 he conducted a seminar on psychiatry and the law at the University of Pennsylvania Law School.

A graduate of the University of Michigan Medical School, Dr. Roche is a fellow of APA and a member of the American Psychoanalytic Association. He is on the faculty of the University of Pennsylvania School of Medicine and the Philadelphia Psychoanalytic Institute. He was a founding member of the Pennsylvania Psychiatric Society and served as its president in 1952-53.

Dr. Roche is the fifth winner of the award, the others being Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C.; Dr. Gregory Zilboorg, New York City psychiatrist; Hon. John Biggs, Jr., Chief Judge, U. S. Court of Appeals, Wilmington, Del.; and Professor Henry Weihofen, College of Law, University of New Mexico, Albuquerque. The award commemorates Dr. Isaac Ray, a founder of the APA, whose *Treatise on the Medical Jurisprudence of Insanity* published in 1838 was for many years the standard work on the subject.

TEXAS PAPER WINS BELL AWARD

The Austin (Texas) *American-Statesman* received the National Mental Health Bell Award for 1955 in ceremonies May 2 in Austin. The award, a bronze facsimile of the Mental Health Bell mounted on a walnut plaque, is given each year by the National Association for

Mental Health to an American daily newspaper making an outstanding contribution to the fight against mental illness.

Factors considered in selecting the award-winner included: dissemination to the public of mental health news, information and opinion; publicizing and editorially supporting local, state and national mental health programs, objectives and fund drives; leadership in campaigns to secure new or improved mental health services for the prevention and treatment of mental illness; any other editorial contributions to the fight against mental illness and the advancement of good mental health.

DAY HOSPITALS

At the end of ten years' operation, the day hospital which was first established in the Allan Memorial Institute, Royal Victoria Hospital, Montreal, has been reviewed. It has been exceedingly successful and similar day hospitals have now been established in Canada, the United States, and Britain. Patients come from 9:00 a.m. to 5:00 p.m. each day except Sunday. All types of patients that can be admitted to a day and night division of a general hospital can be accepted in a day hospital, and all forms of treatment, with the possible exception of coma insulin, can be carried on in the day hospital. The cost to the patient is about one-half to one-third of that to the patient who has to reside overnight.

The first of two day hospital centers to be organized by the New York State Department of Mental Hygiene opened at Hudson River State Hospital, Poughkeepsie. The day hospital is a pilot project to determine the value of psychiatric and supportive therapy for suitable mental patients in a hospital during the daytime. Patients at the new center will receive psychiatric care on a voluntary outpatient basis, during the day, remaining for the rest of the time at their homes or continuing insofar as possible with their family and community activities.

The second day hospital will open in the near future in connection with the Brooklyn Aftercare Clinic.

The Hudson River day center occupies one ground floor wing of a new building. The wing has a separate front entrance and forms a self-contained unit independent from the hospital and the rest of the building. It consists of sixteen rooms with ample physical facilities for all types of therapies, offices, and reception services. The treatment area will consist of a treatment unit with ten beds, an occupational therapy studio, and a rehabilitation area including a library and recreation room. Dining facilities also will be available.

The day hospital has been designed for the care of adults eighteen years or older and will operate five days a week from 8:30 a.m. to 4:00

p.m. All standard psychiatric and somatic therapies, including drugs, electric shock, and insulin will be given.

Patients will be referred to the day hospital primarily by community physicians and social agencies and on a volunteer basis. Cases also may be accepted after provisional release from a state hospital to complete the patients' course of treatment or for social and vocational readaptation as a means of helping to tide them over in making an adjustment from the hospital to the community. In both cases, much stress will be laid on the closest possible cooperation with the community and the patients' families, employers, or friends. No rigid rules have been set up to govern admissions, but each case will be evaluated on its individual merits depending on the type and degree of resocialization expected.

A staff of fourteen will administer the day hospital, headed by Dr. O. Arnold Kilpatrick, director of the Hudson River State Hospital. Dr. Marian Axel will be the psychiatrist in charge of the center. The staff will also include a psychiatrist, two nurses, a social worker, occupational therapist, recreational worker, two male and four female psychiatric aides, and a secretary-receptionist.

ESTABLISHES NATIONAL AWARDS

Marshall Field announced today the formation of Marshall Field Awards, Inc., a non-profit organization "to recognize and reward fundamental and imaginative contributions to the well-being of children." Six to nine awards will be made annually to individuals, organizations, and communities in the fields of education, physical and mental development, social welfare and communications. Each award will consist of \$2,000, a scroll, and a statuette. The winners will be selected by a board of directors composed of recognized authorities in child life. The first awards will be made this year.

In announcing the awards program, Mr. Field stressed the considerations that led to its establishment: "Although few would quarrel with the controlling importance of children to America's future, I believe we have not done all we can or should to assure for our young people the opportunity for their fullest physical, mental, and social development. I think the reasons for this deficiency are, first, that we have not devoted a large enough portion of our national resources in manpower and money to the professional fields which serve children and, second, that we have not made those professional fields sufficiently high in prestige or reward to attract adequate numbers of top-notch personnel needed to make new and important contributions to the well-being of children.

"Our awards are designed to help meet these deficiencies. It is

our hope that they will focus public attention on children's needs and on the areas in which improved services are urgently required. The awards will call attention to constructive programs which set an example for others to follow. We hope, too, that the granting of these awards will, in some measure, raise the status of the professions devoted to children and will stimulate the making of additional significant contributions to the betterment of child life."

Mr. Field has long been active in work devoted to children both through the Field Foundation, which he established in 1940, and as president since 1951 of the Child Welfare League of America.

Nominations for possible award winners will be solicited by the new organization on a nation-wide basis. All nominations will be screened and final selections will be made by the board of directors. International awards may also be granted at the discretion of the directors.

The following criteria will be used in judging work nominated for awards: 1. Does it directly help children (defined as those who have not yet reached legal majority)? 2. Does it benefit a large or significant group of children? 3. Can it be applied or adapted for use by others? 4. Is it consistent with professional standards in the field? 5. Does it represent an original or extraordinary service? 6. Will it promote sound development of children? 7. Will it stimulate public interest in the needs of children? 8. Does it open new dimensions in the lives of children? 9. Is it being recognized nationally for the first time? 10. Are those who did the actual work being rewarded?

Members of the board of directors in addition to Mr. Field are: Leona Baumgartner, M.D., New York City Commissioner of Health; Mrs. Richard J. Bernhard, president, Arthur Lehman Counseling Service; Sarah Gibson Blanding, president, Vassar College; James Brown, IV, executive director, Chicago Community Trust; Hon. Ralph J. Bunche, Under Secretary Without Department, United Nations; Martha M. Eliot, M.D., chief, U. S. Children's Bureau; Ruth Pruyn Field, New York City; Leonard H. Goldenson, president, American Broadcasting-Paramount Theatres; John Gunther, New York City; Herold C. Hunt, Under Secretary of Health, Education, and Welfare; Charles A. Janeway, M.D., professor of pediatrics, Harvard University Medical School; Clark Kerr, chancellor, University of California; Mrs. David M. Levy, president, Citizens' Committee for Children of New York City; Ernest K. Lindley, director, Washington Bureau, Newsweek; Leonard W. Mayo, director, Association for the Aid of Crippled Children; William C. Menninger, M.D., Menninger Foundation; Hon. Justine Wise Polier, Children's Court, New York City; Mrs. Anna M. Rosenberg, New York City; Howard A. Rusk, M.D., associate editor, New York Times.

Offices for the new organization have been opened at 598 Madison Avenue, New York City. The deadline for nominations for the first awards is October 1, 1956.

NAMH, NIMH ANNOUNCE RESEARCH GRANTS

Grants totaling \$82,900 for 22 research projects on schizophrenia were announced May 6 by F. Barry Ryan, Jr., president of the National Association for Mental Health. The grants were made from a \$100,000 fund provided by the Supreme Council, 33rd Degree, Scottish Rite Freemasonry, Northern Masonic Jurisdiction, which is directing the research program through the National Association for Mental Health. In the last 22 years, the Scottish Rite has provided more than \$1,100,000 for this continuing research program.

Forty-two new research grants were recently awarded by the National Institute of Mental Health on the recommendation of the National Advisory Mental Health Council. The new awards, totaling just under \$700,000, went to the support of 42 approved projects at academic, scientific, and medical centers throughout the country. The Advisory Council also approved continuation of 102 research grants totaling \$1,713,272.

The following grants were announced by the NAMH:

Dr. Kenneth Appel, Institute of the Pennsylvania Hospital, Philadelphia, for an investigation of the effects of carbon dioxide treatment in early schizophrenia; \$5100.

Dr. Philip Bard, Johns Hopkins University, Baltimore, for an experimental study of aggression and anger in animals; \$1000.

Dr. George H. Bishop, of Washington University School of Medicine, St. Louis, for a study of brain interconnections through the use of small electrodes to record the electrical impulses from the brain in response to stimuli; \$2500.

Dr. C. H. Hardin Branch, University of Utah, for an investigation of urinary metabolic abnormalities in schizophrenic patients; \$5000.

Dr. Robert Allen Cleghorn, McGill University, Montreal, for the assessment of neurohumoral and endocrine functions in schizophrenia; \$4000.

Dr. Daniel H. Funkenstein, Boston Psychopathic Hospital, for an investigation of stress reactions and schizophrenia; \$4000.

Dr. Hudson Hoagland, Worcester Foundation for Experimental Biology, Shrewsbury, Mass., for a study of the relation of adrenal function to schizophrenia; \$5000.

Dr. Irving Kaufman, Judge Baker Guidance Center, Boston, for a study of pre-schizophrenic children, involving a careful study of the psychological problems of the child's mother, which has a serious impact upon his personality development; \$4800.

Dr. Franz J. Kallman, New York State Psychiatric Institute, for twin and sibship study of pre-adolescent forms of schizophrenia; \$4000.

Dr. Peter H. Knapp, Boston University School of Medicine, for an investigation of the relation of asthma to schizophrenia; \$4000.

Dr. Zygmunt A. Pietrowski, New Jersey Neuropsychiatric Institute, Princeton, for a study of projective techniques in early schizophrenia; \$3000.

Dr. Marian Putnam, James Jackson Putnam Children's Center, Roxbury, Mass., for an investigation of the effects of adverse childhood experiences in undermining personality and rendering the individual susceptible to mental illness; \$4500.

Dr. Ralph D. Rabinovitch, Neuropsychiatric Institute, University of Michigan, Ann Arbor, for a study of childhood schizophrenia; \$4000.

Dr. Carl Schmidt, University of Pennsylvania School of Medicine, for a study of the utilization of oxygen by brain tissue; \$3000.

Dr. Heinrich Waelsch, New York State Psychiatric Institute, for the study of chemical changes involving nuclear protein in schizophrenia; \$3000.

Dr. Alfred Washburn, Child Research Council, University of Colorado, Denver, for studies in the psychological development of children; \$5000.

Dr. John C. Whitehorn, Johns Hopkins University, for a study of the personal (psychological) characteristics of psychiatrists that render them more effective or less effective with certain types of patients, especially schizophrenic patients; \$5000.

Miss Neta A. Neumann, St. Elizabeths Hospital, Washington, D. C., for a study of the part played by basal ganglia structures in the development of schizophrenia (the basal ganglia are masses of cells deep in the brain tissue, separate from the cortex; they are, among other things, heavily involved in emotional expression); \$4000.

Dr. Ian Stevenson, Louisiana State University School of Medicine, New Orleans, for an investigation of certain psychological and biochemical aspects of schizophrenia and experimental psychoses, using lysergic acid and other drugs that bring about hallucinations artificially; \$6000.

Dr. Francis J. Gerty and Dr. Ivan Boszormenyi-Nagy, Neuropsychiatric Institute, University of Illinois, Chicago, for a study of the diagnostic aspects of unusual chemical changes going on within the red blood cells of schizophrenia patients; \$3500.

Professor Erwin Chargaff, Cell Chemistry Laboratory, Columbia University College of Physicians and Surgeons, New York City, for

research on the nuclear proteins and nuclear acids of the brain. These are the peculiar chemical components of the nuclei of cells; \$2000.

Dr. George L. Engle, University of Rochester, to provide stipends for students between the third and fourth year of medical school at the University of Rochester to work in the field of research during the summer and thereby receive training in the methods of research; \$500.

DEDICATES PAVILION AT ST. ELIZABETHS

Pointing out that mental illness took an annual toll of nearly \$2,000,000,000 from the nation's economy, Vice-President Richard M. Nixon dedicated the new Dorothea Lynde Dix pavilion of St. Elizabeths Hospital in Washington, D. C., April 13.

He added that it was fitting that the \$6,000,000 building, designed to return patients to community life as quickly as possible, should be named for the woman who pioneered enlightened hospital treatment. He also linked the dedication with the observance of National Mental Health Week April 29 to May 5.

Features of the federal hospital's new facilities include lightweight upholstered furniture, reproductions of art masterpieces in all rooms, window screens instead of bars, a patio for summer parties, and barber shops where men patients may shave themselves.

NEW PROCEDURE TO SPEED GRANTS

The Public Health Service has announced a new procedure to expedite the processing of research grant applications for requests which do not exceed \$2,000 plus indirect costs and which do not ask support for more than one year. Such applications will be accepted and processed on receipt and are not therefore subject to the usual deadlines for submission prior to review. Council recommendations can be expected on these applications within one to four months from the time of submission. These procedures do not apply for requests for supplements to existing grants. Address all applications as well as requests for forms or additional information to the Division of Research Grants, National Institutes of Health, Bethesda 14, Md.

TO ATTEND CONFERENCE

Mrs. Evelyn D. Adlerblum of New York City will represent the National Association for Mental Health and the New York University School of Education this summer at an international conference on education and mental health in home, school and community. The conference will meet in Utrecht, Holland, July 28 to August 9. Mrs. Adlerblum, an assistant professor of education at NYU, originated

practical techniques for applying mental health concepts in kindergarten and the first grade.

LOS ANGELES HOSPITAL OPENS PSYCHIATRIC DEPARTMENT

First patients in Mt. Sinai Hospital's new psychiatric department were admitted April 16, according to Dr. Franz Alexander, chief of psychiatry and director of the Los Angeles hospital's Psychiatric Research Institute. With the opening of the new facility, Mt. Sinai becomes the only non-governmental hospital in Southern California to provide free and part-pay beds for mentally and emotionally disturbed adults. Thirty-five beds will be available for patients, half of them free. Dr. Alexander stressed that the patient will be treated as a whole person, receiving care for physical as well as mental needs. Patients may be treated by their own psychiatrists while hospitalized at Mt. Sinai, but all care will be under supervision of the hospital staff and a uniformity of standards will be observed. Twenty-four psychiatrists, headed by Dr. Steven D. Schwartz, chief of inpatient service, have been appointed to the staff, and all have agreed to provide free care to patients in need.

The hospital's psychiatric outpatient clinic is expected to be in operation by the end of the summer.

Mt. Sinai also is undertaking a major psychiatric research program. The Psychiatric Research Institute is investigating the basic psychological and biological causes of mental illness and emotional disturbances.

NEW YORK MENTAL HOSPITALS NOTE POPULATION DECREASE

For the first time since World War II the records of the New York State Department of Mental Hygiene show a decrease in the number of mental hospital patients.

Reporting to Governor Harriman at the close of the fiscal year, Dr. Paul H. Hoch, commissioner, pointed out that while there has been no essential change in the number of admissions, there has been a sufficient increase in the number of releases during the last fiscal year not only to offset the admissions but to effect a slight decrease in the net population. For the past ten years the resident population of the mental hospitals has been increasing by about 2,000 patients each year. On March 31, 1956, however, the resident population (92,916 patients) was actually 500 less than it was on March 31, 1955. The difference lies in the fact that during this period there was an increase of 2,600, or 23 percent, over the previous year in the number of patients released from the hospitals.

The improvement in release rates was attributed by Dr. Hoch to

intensified treatment, including more extensive use of tranquilizing drugs. There may be other factors, he said, which are not measurable at this time.

"While these statistics are most encouraging," Dr. Hoch warned, "it is too soon to know whether they represent an actual alteration in the rising trend or merely a temporary fluctuation. Certainly the decrease is insufficient to have any validity at this time as an indication of complete reversal. There is more reason to hope that we may be able just to hold the line—that is, to balance releases against admissions so that as time goes on we will no longer be faced with the appalling necessity of building the equivalent of a new institution every year to accommodate the additional patients. Instead we would be able to use our resources for more treatment, training and research.

"It is still imperative," he declared, "that we continue our present building program. The institutions are still 30 percent overcrowded and many obsolescent buildings must be replaced. Furthermore, we must have proper facilities if we are to provide good modern treatment."

MENTAL PATIENT STATISTICS SHOW INCREASES

Mental hospital figures in basic categories showed a "substantial increase" in fiscal 1955 over the year before, according to statistics compiled by the biometrics branch of the National Institute of Mental Health from summary data supplied by the 48 states and the District of Columbia. Increases ranged from 1.2 percent for resident patients at the end of the year to 9.8 percent for readmissions. Other categories showing increases were first admissions (1.9 percent), discharges (2.4), deaths in mental hospitals (4.3), personnel employed full-time at the end of the year (5.1), total maintenance expenditures (9.3), and average expenditure per capita (7.7).

SKF JOINS NATIONAL HEALTH COUNCIL

Smith, Kline & French Laboratories, pharmaceutical manufacturers, became the fifty-first member of the National Health Council through vote of the Council's delegates in June. The 115-year-old company is the first pharmaceutical concern to share in the cooperative program of the Council, active members of which are voluntary health organizations and professional societies in the health field. Governmental health agencies are advisory members, and civic groups with health interests hold associate memberships. SKF Laboratories joins two other sustaining members, the Metropolitan Life Insurance Company and the Equitable Life Assurance Society of the United States.

"We are wholly in agreement with the specific goals of the National

Health Council," said Francis Boyer, president of Smith, Kline & French, "and have always felt that association between pharmaceutical firms and ethical health organizations cannot help being beneficial to both parties and to medicine in general." A foundation established by SKF carries on a \$125,000-a-year research and training grant program in the mental health field.

The addition brings to an all-time high the membership of the Council which was founded in 1921 by ten organizations. Council activities include an annual National Health Forum. The 1957 Forum, to be held in Cincinnati March 20 and 21, will be concerned with mental health.

Emotional conflicts between dentists and their patients is one of the most difficult problems the dental profession faces today, according to Dr. George W. Teuscher, dean of Northwestern University dental school. As an approach to the problem, Northwestern sponsored a conference June 15 and 16 for faculty members of the nation's dental schools on the care of the child patient.

"There are tens of thousands of children who receive no dental care only because of existing emotional conflicts," Dean Teuscher said. "These conflicts could be corrected with proper management taught in our dental schools. By teaching dentists how to manage children, correct relationships can be established and habits formed early in the child's life."

The two-year-old is not too young for his first visit to a dentist, according to Dean Teuscher.

Speakers at the seminar included Miss Helen Ross, executive secretary of the Chicago Institute for Psychoanalysis, Dr. Ner Littner, child psychologist, and Dr. Harvey Lewis, psychiatrist and anthropologist.

Demands for mental health services in New York City far outrun the capacity of available facilities, the Welfare and Health Council reported in May. The relation of real need to current demands is insufficiently known, the Council says, in calling for a comprehensive survey as the most urgent requirement in the field. J. Donald Kingsley, executive director, urged that the New York Community Mental Health Board sponsor the survey as a basis for sounder planning in the entire field and for allocating funds under the Community Mental Health Services Act.

"In all situations where demand outruns supply, priorities must be determined," Mr. Kingsley said. "At present, we simply do not have the facts to determine sound priorities in this area. The Council report brings together much information on mental health needs

and facilities, but more detailed information is essential for sound planning."

The report outlines an immediate nine-point program for improving mental health and mental health services in the city:

1. A training program for key people in health and welfare organizations and in industry so that they learn enough of the symptoms of emotional disturbance to recognize individuals needing help and to know the resources where help is obtainable.

2. More effective information and referral services, greater coordination among existing services, and more consultation between referral services and diagnostic and treatment agencies regarding in-take policies.

3. Additional outpatient clinic services, especially for children; services for older persons; study of geographic distribution of services; and relation of plans for new services to demonstrated need.

4. Rehabilitation services for patients with psychiatric disorders, including more half-way service, sheltered workshops, and sheltered living environment for emotionally disturbed persons; better vocational service; and greater use of existing vocational advisory and training services.

5. Increased funds for training workers in mental health.

6. Public funds not to replace voluntary fund-raising efforts.

7. Careful study of existing laws and standards for personnel and facilities. (The report noted that the New York State Society for Mental Health has begun a review of laws.)

8. Exploration of all promising approaches toward maintenance, protection, and promotion of mental health, to accumulate tested knowledge in these fields.

9. More liberal interpretation of the scope of the Mental Health Services Act, so that reimbursement for new and expanded services in protection and promotion of mental health will be available as knowledge of these activities increases.

Copies of the statement, titled "Mental Health Needs and Facilities in New York City," will be available at a charge of 50¢ each from the Publications Department, Welfare and Health Council of New York City, 44 East 23rd Street, New York 10.

Two New York City psychiatrists have been named consultants to the New York State Department of Mental Hygiene by Dr. Paul H. Hoch, Commissioner of Mental Hygiene. Appointed to the honorary posts were Dr. M. Ralph Kaufman, chief of psychiatry at Mount Sinai Hospital, and Dr. John Millet, who is affiliated with Presbyterian Hospital. Both men were charter members of the State Mental Hy-

giene Council and recently completed their terms of office after serving five years. Dr. Hoch said they were appointed consultants in recognition of the outstanding services they have performed for the department especially during their tenure on the Mental Hygiene Council.

Dr. M. G. Candau, director-general of the World Health Organization, has announced the appointment of Dr. E. Eduardo Krapf, associate professor of psychiatry at the University of Buenos Aires, as chief of the mental health section of WHO, with headquarters in Geneva. Dr. Krapf, president-elect of the World Federation for Mental Health, has been associated with the National Hospital of Neuropsychiatry and was a psychiatric consultant with the armed forces of Argentina. He obtained his medical degrees at the Universities of Munich and Buenos Aires and holds the titles of professor extraordinary at the University of Cologne and of honorary professor at St. Thomas University, Manila. He succeeds Dr. G. R. Hargreaves in the WHO post.

ORGANIZE NATIONAL ACADEMY OF RELIGION AND MENTAL HEALTH

Following three years of preliminary discussions with psychiatrists, theologians, cultural anthropologists, sociologists, and psychologists, a new National Academy of Religion and Mental Health has opened offices in the New York Academy of Medicine, 2 East 103rd Street, New York 29. Kenneth E. Appel, M.D., president of the Joint Commission on Mental Illness and Health, professor of psychiatry at the University of Pennsylvania and past president of the American Psychiatric Association, has been elected president.

The academy, a non-profit organization engaged in research and education in all relationships between religion and health, especially mental health, has been organized on an interfaith and multidisciplinary basis. Close working relationships have been established with Roman Catholic, Jewish and Protestant theologians and psychologically trained clergymen, some of whom are serving on an advisory council.

The academy expects to sponsor scientific research in relationships between religion and mental health; sponsor conferences between theologians, psychiatrists and others professionally engaged in mental health; stimulate local conferences; obtain fellowships, scholarships and grants-in-aid for clergymen of all faiths desiring graduate and clinical training in pastoral psychology and mental health concepts; interpret theological doctrines and attitudes to mental health workers; circulate a lending library; sponsor pilot courses of psychological instruction in certain seminaries of the three major faiths; publish

a monthly newsletter; prepare pamphlets and articles; serve as a resource center for information regarding relationships between religion and mental health; and provide consultative and advisory services.

No other organization of this kind has been established either in this country or elsewhere. The academy has been elected a member of the World Federation for Mental Health. Memberships in the academy are being solicited from professional workers and interested laymen.

The research committee includes John M. Cotton, M.D., director of psychiatry at St. Luke's Hospital, New York; Harvey J. Tompkins, M.D., director of the Jacob R. Reiss Mental Health Pavilion, St. Vincent's Hospital, New York; Nolan C. S. Lewis, M.D., director of research at the N. J. Neuro Psychiatric Institute, Princeton, N. J.; and Earl A. Loomis, Jr., M.D., professor of psychiatry and religion at Union Theological Seminary, New York. The educational committee includes the Rev. William C. Bier, S.J., associate professor of psychology at Fordham University, New York; the Rev. Otis R. Rice, D.D., religious director at St. Luke's Hospital, New York; the Rev. Sankey L. Blanton, D.D., president of Crozer Baptist Seminary, Chester, Pa.

Inquiries concerning the academy should be made to the Rev. George C. Anderson, director.

Another example of the growing interaction between psychiatry and religion is the establishment of a department of psychiatry in the Jewish Theological Seminary of America to acquaint "future rabbis with certain problems of the individual and the community as viewed by modern psychiatry." Fifteen teaching sessions presided over by psychiatrists will help the rabbi develop awareness of the psychological needs of his congregants, especially the young people, and also assist him in distinguishing between normal temporary emotional stress and mental illness. The psychiatric faculty, all members of the New York Institute of Psychoanalysis, described the purpose and content of the training course as the teaching of "moral dynamic psychology, i.e., an understanding of moral behavior, as well as the recognition of mental illness and the principles of conflicts."

A recent questionnaire poll of clergymen of all faiths in the western states, Hawaii, and Alaska, reveals that a majority of them favor closer working ties with the mental health professions in meeting community mental health needs. It was also brought out that a preponderant number of pastors spend about one-fourth of their working hours dealing with emotional problems of church members. These disclosures, announced by the California State Department of Mental Hygiene, appeared in a report on a western mental health training

and research survey supported by the U. S. Public Health Service. The survey showed that clergymen generally feel that increased availability of psychiatrists and clinical psychologists plus fuller training in these fields for religious leaders could be of definite value to the clergyman's present role of marriage counselor, youth leader, and guide to the needy, ill, and emotionally distressed. Several respondents pointed to the need for better liaison between the mental hospital and the clergymen following the release of mental patients. The clergyman, they noted, if contacted upon the release of a hospital patient, can do much in follow-up efforts to assist the convalescent person in regaining a useful role in his community.

SIGNIFICANT MEETINGS

The ninth annual meeting of the World Federation for Mental Health will be held in West Berlin, German, from August 12 to 17, 1956.

The theme of the meeting will be "Mental Health in Home and School."

The program will include plenary sessions, discussion groups, a special film group, technical sections, film sessions open to all participants, and the general session of WFMH, at which the new president will take office and elections for new officers and members of the executive board will be held.

The topics proposed for the plenary sessions include: the concepts of mental health and its international implications; a study of the relations between the mother and the new-born child; the mental health of the pre-school child and his family; the mental health of child, family, and school at the time of school entry; problems of change of environment and school; the provision of psychological services for pre-school and school children; the needs of sub-normal and highly gifted children; the recognition and treatment of difficulties in school; and mental health problems at the time of leaving school.

A number of participants will be able to join small informal discussion groups. For others there will be technical sections, at which one or two short papers will be presented on matters of medical, educational, and social interest in relation to mental health, which will then be the subject of general discussion.

The National Council on the Psychological Aspects of Disability will hold its annual meeting August 30 and 31 in Chicago in connection with the convention of the American Psychological Association. One session will be devoted to "Realistic Vocational Counseling in

Rehabilitation," another to "Psychological Implications of the Educational Management of Handicapped Children."

The psychological interpretation of children's behavior in various cultures will be the theme of meetings of the International Council of Women Psychologists at the Sherman Hotel in Chicago August 31, in connection with the convention of the American Psychological Association. This theme will be discussed at a luncheon meeting by Miss A. Elizabeth Adams of Surrey, England. Dr. Otto Klineberg will discuss "Problems Raised by the Application of Psychoanalytic Concepts to Children in Various Cultures."

The 14th annual meeting of the American Psychosomatic Society will be held May 4 and 5, 1957, at the Chalfonte-Haddon Hall Hotel in Atlantic City. Dr. I. Arthur Mirsky is president, Dr. Theodore Lidz is president-elect, and Dr. Morton F. Reiser is secretary-treasurer. New members of the council are Drs. Louis Linn, Eugene Meyer, Eric D. Wittkower and Harold G. Wolff.

NAMED CHAIRMAN OF FORUM ON MENTAL HEALTH

Dr. Francis J. Braceland, psychiatrist-in-chief of the Institute of Living in Hartford, Conn., and president of the American Psychiatric Association, has been appointed chairman of the 1957 National Health Forum Committee by Dr. Leona Baumgartner, president of the National Health Council and health commissioner of New York City. The 1957 Forum, one of an annual series conducted by the Council in the interests of its 51 national organization members, will focus on fostering mental health in America with emphasis on constructive actions and attitudes that may be taken by all health organizations. The Forum will be held in Cincinnati, March 20 and 21.

"Nine million Americans are suffering from mental illness serious enough to warrant treatment," said Dr. Baumgartner, "and half of our hospital beds are occupied by mental patients. Those facts point to a problem of national emergency proportions. Everyone can and must assume some share of responsibility for the preservation and promotion of mental health."

She said that she had asked Dr. Braceland to take the committee chairmanship partly because of his striking achievements at the Hartford Institute in returning the mentally ill to normal living.

"In addition," said Dr. Baumgartner, "Dr. Braceland, through his writing and speaking, is leading new efforts to bring sound psychiatric principles to bear upon everyday living through which we may hope to reduce the stresses of modern civilization that seem to lead to mental illness."

Dr. Braceland met June 4 with the nucleus of his committee. In addition to Richard P. Swigart, executive director, National Associa-

tion for Mental Health, members then included: Raymond H. Barrows, executive director, National Foundation for Infantile Paralysis, and chairman, NHC Forum Planning Committee; Richard C. Bostwick, Smith, Kline and French Laboratories; Robert H. Felix, M.D., director, National Institute of Mental Health; E. M. Gruenberg, M.D., Milbank Memorial Fund; Paul V. Lemkau, M.D., director, New York City Community Mental Health Board; Hildegard E. Peplau, R.N., Ed.D., director of the program in advanced psychiatric nursing of Rutgers University; R. J. Plunkett, M.D., Joint Commission on Mental Illness and Health; John D. Porterfield, M.D., director, Ohio State Department of Mental Hygiene and Correction; Mildred C. Scoville, treasurer of the World Federation for Mental Health; Irving S. Shapiro, Ph.D., assistant director of preventive medicine and health education, Health Insurance Plan of Greater New York; Sidney Spector, director, Interstate Clearing House on Mental Health, Council of State Governments; Dr. George D. Stoddard, chairman of the directing committee, New York University Self Study, and dean-elect of the School of Education.

Others will be invited to join the committee, which will hold another summer meeting.

STRESS SIGNIFICANCE OF FAMILY RELATIONSHIPS

The importance of the family unit in mental health was a recurring theme throughout the thirty-third annual meeting of the American Orthopsychiatric Association in New York, March 15 to 17. Sessions were attended by nearly 5,000 psychiatrists, psychologists, psychiatric social workers, and others interested in community mental health, psychiatric treatment, and institutional administration.

Luther E. Woodward, Ph.D., senior community mental health representative for the New York State Department of Mental Hygiene, was installed as president at the conclusion of the meeting, succeeding Dr. Exie E. Welsch, child psychiatrist and associate in psychiatry, College of Physicians and Surgeons, Columbia University. Other officers for 1956-7 are president-elect, Reginald S. Lourie, M.D., director of the department of psychiatry, Children's Hospital, Washington, D. C.; vice-president, Theodora M. Abel, Ph.D., director of psychology, Postgraduate Center of Psychotherapy, New York, and adjunct professor of psychology, Long Island University; and treasurer, S. Harcourt Peppard, M.D., director of the Essex County Guidance Center, East Orange, N. J.

A resolution passed at the final session placed the association on record as officially in favor of attempts to achieve "effective, psychologically sound, and lawful transition from segregated to non-segregated public schools" on the basis that "research findings, clini-

cal studies, and general observation indicate that racial segregation, discrimination, and arbitrary prejudices damage and distort the personality of children" and that "a racially non-segregated society will be conducive to the good mental health and well-being of the entire nation."

Dr. Abram Kardiner, dean of the Psychoanalytic Clinic at Columbia University, told a session on orthopsychiatry and prevention that today's mental problems are related to the fact that the home has been "culturally invaded" by the mass media, with the result that the parental role in "cultivation of the social emotions" of children has been usurped. A related problem, he said, is that we are living in an age of anxiety because "there is an ever-widening gap between what we have, in terms of physical comforts, and what we want."

Other papers emphasizing the family unit included one by Joseph Weinreb, M.D., director of the Worcester (Mass.) Child Guidance Clinic, on the dynamics of direct consultation to parents of disturbed children emphasizing the importance of "helping the parent in a dynamic way without depriving him of his status as a parent."

Another session on therapy with parents included a paper by Leon Eisenberg, M.D., of the Johns Hopkins Hospital, Baltimore, on a study of 100 autistic children showing that distorted paternal attitudes "emerge as prominent features but do not conform to a single stereotype." Three staff members of the Guidance Center of Buffalo—David Hallowitz, Robert G. Clement, and Albert V. Cutter, M.D.—described five years' experience in treating both parents together and concluded that "there is enormous potential in this process in terms of getting at the deeper sources of a child's emotional disturbance." A paper by David Limentani, M.D., Eveleen N. Rexford, M.D., and Maxwell Schleifer, Ph.D., all of the Douglas A. Thom Clinic for Children, Boston, suggested that inadequate knowledge of the father and infrequent treatment for him is a common factor in treatment failures. A workshop session also was devoted to problems of family diagnosis.

In her presidential address, Dr. Welsch reaffirmed the fundamental principles of orthopsychiatry as "a central concern with the individual, but with focus on the multiple factors of a person's living in a search for more comprehensive understanding of human behavior," and the utilization of a team including non-medical members with specialized skills, among them the psychologist and psychiatric social worker, "because the nature of personality requires a team structure to serve it adequately and comprehensively."

Albert Deutsch, writer on mental health subjects, pointed out that despite increased public interest in mental illness, "our mental institutions remain for the most part overcrowded, understaffed, ill-equipped; the long waiting-lists for child guidance clinics and other

outpatient services attest to the great volume of frustration; we are desperately short of psychiatrists, psychologists, social workers, nurses, and other mental health personnel—short of everything but patients.”

Ira deA. Reid, Ph.D., professor and chairman of the department of sociology, Haverford College, analyzed mental health aspects of segregation and desegregation and stressed the need for greater understanding of sub-groups and multi-group relationships.

Other topics of major interest included juvenile delinquency, psychiatric treatment of children, psychiatric clinic practices and procedures, community mental health, and mental health services in schools.

HOLD FORUM ON ANXIETY AND TENSION

Insecurity, fear and dissatisfaction throughout the world take a staggering toll in human health and happiness, a panel of top authorities emphasized at the First Annual Forum on Anxiety and Tension April 30 in New York City.

The forum, opening Mental Health Week, analyzed international, racial, labor-management and individual tensions. It was sponsored by CIBA Pharmaceutical Products in cooperation with the National Association for Mental Health.

Opening the conference, F. Barry Ryan, Jr., NAMH president, pointed out that the tensions which make it difficult for the individual human being to live at peace with himself also make it difficult for groups of human beings to live at peace with each other. Noting that no group of sick people has been so neglected as the mentally ill, Mr. Ryan called for research to find and eliminate the causes of mental and emotional disorders.

He also read a telegram from President Eisenhower: “Please extend my greetings to those participating in the forthcoming Annual Forum on Anxiety and Tension. During Mental Health Week, a time when we are all asked to put forth a united effort to improve the lot of the mentally ill, it is fitting that you search out and discuss together some of the basic factors that undermine mental health. I extend to all of you my best wishes for a successful series of deliberations.”

“Some researchers,” Dr. Kenneth E. Appel, NAMH board member, told the audience, “believe that emotional factors play a role in cancer, infectious diseases and accidents. If this is true, dissatisfaction is a prime mover in all the principal causes of death.” The mental health movement, he added, must help every physician and citizen to realize that satisfaction is essential to health.

Dr. Harvey J. Tompkins, chairman of the NAMH professional advisory committee, reported that an increasing number of mental patients who previously would require hospitalization now are being treated effectively at home, in the physician’s office or in an outpatient

clinic. But if we are to reduce the number of hospitalized psychiatric patients to a minimum, there is need, he said, for a greater acceptance of responsibility by the ordinary citizen.

Other speakers were Mrs. Eleanor Roosevelt, Sen. Michael J. Mansfield of Montana, Rep. Walter H. Judd of Minnesota, James B. Carey, president of the International Union of Electrical, Radio and Machine Workers (AFL-CIO), Patrick B. McGinnis, president of the Boston & Maine Railroad, Dr. Channing Tobias, chairman of the board of the National Association for the Advancement of Colored People, Clark M. Eichelberger, executive director of the American Association for the United Nations, T. F. Davies Haines, CIBA president, and Dr. Margaret Mead, eminent anthropologist and forum chairman.

PUBLICATIONS

Nearly 2,000 psychiatric clinics and other services for the mentally ill are listed in the eleventh edition of a directory of mental health resources in the United States and territories, published in June by the National Association for Mental Health.

The directory supplies information on over 1,200 regularly scheduled full-time and part-time outpatient psychiatric services, scores of state hospitals and institutions for the mentally ill, mentally defective and epileptic, Veterans Administration hospitals, state departments dealing with mental health, and 500 state and local mental health associations.

The information was compiled jointly by the National Association for Mental Health and the National Institute of Mental Health of the U. S. Public Health Service. In a foreword Dr. R. H. Felix, NIMH director, and Dr. George S. Stevenson, NAMH consultant, point out that the directory will be a useful reference book for professional personnel "in whatever capacity they serve the individual and the community."

The co-sponsors emphasize that the directory should also stimulate "a united effort to develop greater public understanding of mental health problems and informed citizen action." They note that the organization of many more mental health associations—now being undertaken by field workers of the National Association for Mental Health—will give the public "a medium through which to channel interest and support for mental health services of all types."

The directory lists psychiatric clinics by location, and gives details of sponsorship, geographic area of service, special groups served, age limitations on patients, clinic schedules, and number and type of professional staffs.

The co-sponsors emphasize that they have made no attempt to appraise the work of the clinics listed. "The directory is not to be

regarded in any sense as an accredited list of clinics," they caution, "and no endorsement of a particular clinic is implied by including it."

Although additional outpatient clinics and improved mental hospitals are needed, according to Dr. Felix and Dr. Stevenson, acute shortage of mental health personnel will slow the growth of psychiatric services for years to come.

The directory is available from state mental health associations and from the headquarters of the National Association for Mental Health, 1790 Broadway, New York City, for \$1.50, with special prices for quantity orders.

The Committee on Publications of Washington University has announced the publication of a new book in the Washington University Studies series, *Theory and Treatment of the Psychoses: Some Newer Aspects*.

The book contains addresses delivered at the dedication of the Renard Hospital, St. Louis: "Psychiatry in the General Hospital," Alan Gregg, M.D.; "A Psychiatrist Looks at Psychiatry," Stanley Cobb, M.D.; "Theoretical Contribution to the Concept of Milieu Therapy," Alfred M. Stanton, M.D.; "Strategy and Tactics in Psychiatric Therapy," John C. Whitehorn, M.D.; "Some Sociological Aspects of the Psychoses," F. D. Redlich, M.D.; "What Is Psychotic Behavior?," B. F. Skinner, Ph.D.; "Major Themes," George Saslow, M.D.; "Historical Note," Edwin F. Gildea, M.D., and Margaret C.-L. Gildea, M.D.

Orders may be placed through the Committee on Publications, Washington University, St. Louis 5, Mo., at \$2.00 per copy.

A new pamphlet, "Pastoral Help in Serious Mental Illness," will be made available this month for use by clergymen of all faiths.

The pamphlet, produced by the National Association for Mental Health, is the third of a special series designed to give the clergy an understanding of psychiatric disorders and their effects on the patient, his family and the community. It was written by the Rev. Henry H. Wiesbauer, Protestant chaplain of Westborough (Mass.) State Hospital and rector of St. Paul's Episcopal Church, Hopkinton, Mass.

Noting that the clergyman is often the first person to whom a mentally ill individual or his family turns for help, the 12-page pamphlet tells the minister how to recognize a psychotic parishioner and refer him to appropriate community resources. It also suggests ways in which the minister can cooperate effectively with the psychiatrist and with the patient's family before, during and after hospitalization.

Earlier pamphlets in the series are "The Clergy and Mental Health," which emphasizes the extent of mental illness and suggests

ways in which a clergyman can serve the mental health needs of his congregation and community, and "Ministering to Families of the Mentally Ill," for clergymen and everyone professionally concerned with the need for counseling families of the mentally ill.

Other educational services provided by the National Association for Mental Health and its affiliated state and local associations to clergymen and church groups are suggestions for sermons on mental health topics, information on mental diseases and common emotional problems, workshops and institutes on religion and mental health, and mental health films, filmstrips, dramatic sketches and other audio-visual aids.

The new pamphlet is available to the general public for 10¢ a copy, with special rates for quantity lots.

A tremendous unfilled demand for trained social workers exists throughout the nation, asserts Lucy Freeman in *Better Human Relations—The Challenge of Social Work*, a pamphlet published recently by the Public Affairs Committee. "At least 50,000 additional recruits will be needed in the next decade," according to an estimate of the Council on Social Work Education, which cooperated in the preparation of the pamphlet. "For those who have the requisite professional education, social work offers a tremendous opportunity for service. Severe shortages exist throughout the country," it points out.

"Most people face, at some time in their lives, a situation in which they must depend on someone else for help," Miss Freeman declares. "But the kind of help that people need varies widely. They may . . . need help in their relations with other people. Or they may need help in meeting the problems of the world about them, in earning a living, or in meeting sickness or disaster. Most of the problems are complex. They combine environmental strain and emotional stress—and each makes the other more difficult.

"One of the tasks of the social workers," Miss Freeman continues, "is to help the individual determine the nature of his need and how it can be met. Frequently the skill of the social workers makes it possible to give the individual asking help sufficient insight into his problem so that he can follow a course of action mutually agreed upon.

"Concern for people and a desire to help them are prerequisites for anyone entering the social work field," the author continues. "But the social worker of today needs more than these qualities of heart and mind. If he is to help people meet their problems, he must be thoroughly trained for this responsibility. This involves specialized education.

"Even without full professional education, many social workers are

doing a fine job," Miss Freeman concedes. "But the public, more and more, is demanding that the personnel in this basic professional field be professionally prepared. The problems encountered in the practice of social work today call for something beyond the native capacities of even the most gifted. Professional skills, professional attitudes, professional knowledge are needed.

"The professional training of the social worker is designed to help him understand people and the causes of their problems through a scientific knowledge about human behavior and society," she adds. "Social work is both a science and an art in human relations."

The pamphlet is available from the Public Affairs Committee, 22 E. 38th St., New York City, for 25¢ a copy.

The first issue of the Mental Health Book Review Index, which will be published semi-annually, is now available without charge to librarians who have long been seeking this kind of periodical assistance in an important area of interest. The new publication indexes reviews of books on psychology, psychiatry, psychoanalysis, and related subjects, appearing in fifty journals. Created and edited by the subcommittee on book appraisal of the Adult Education Board of the American Library Association, the index is available as a supplement to Vol. VII, No. 3, Jan.-Feb. 1956 of the Psychological Newsletter.

Communications concerning the index should be addressed to Miss Lois Afflerbach, Paul Klapper Library, Queens College, Flushing, L. I.

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THE TEACHER AND THE WITHDRAWN CHILD

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WICKMAN'S early study³ indicated that teachers were not aware of the seriousness of withdrawal in young children and that they were much more concerned with the child who was a behavior problem in class. They felt that the problem child was much more of a mental health risk than was the withdrawn child. Hobson's study¹ about a decade later lent support to the findings of Wickman. A more recent study by Stouffer,² repeating Wickman's procedures, indicated that teachers had advanced considerably in their knowledge of good mental hygiene principles. The present study is an attempt to shed some light on the extent to which teachers understand the needs of the withdrawn child.

Every experienced elementary school teacher has had to cope, at one time or another, with a child or with children in her classes who would be termed "withdrawn." These children seldom or never volunteer for any assignment or special activities and when placed in such activities they frequently function in a listless and inhibited manner. When left to their own devices they frequently resort to solitary, unconstructive activities which are often irritating to those about them. They may tap with their pencils, finger their hair, gaze out the window, doodle with their pens or pencils, and in countless other ways appear to be discharging the tension and energy which other children are putting into more constructive and socializing activities. The pattern of withdrawal, once initiated, tends to reinforce itself and to become more and more pronounced as time passes. The child has less and less contact with other children of his age and becomes less and less capable of functioning with others to his own satisfaction. It is important, then, that the pattern of withdrawal be broken up as

early as possible. This study presents an analysis of the techniques which are reported by one group of teachers at the first and second grade levels to bring the withdrawn child into better social contact with the other children in his classroom.

The data for this study were gathered through the use of a simple questionnaire which was sent out to the first and second grade teachers in the public schools of Jackson, Mich. After giving some background information on the problem of the withdrawn child, the following instructions were given and questions asked:

"On the attached sheet, will you please describe clearly but briefly any procedures, techniques, maneuvers, etc., which you have found particularly effective in bringing the withdrawn child into the group. Please be specific. These should be things you *do*, rather than principles by which you are guided. Describe what materials, if any, are involved. Techniques which you have developed as a result of your own experience are likely to be of most value. Nevertheless, specific techniques which can be used in the classroom are the objectives of this request. Feel free, therefore, to consult with colleagues or to jot down techniques which have been mentioned in courses you have taken, remembering that your own experience is probably the best criterion of what is a good technique for this purpose. Make as many suggestions, and describe as many techniques, as you wish. It is hoped that there will be at least one suggestion from each person who receives this request."

Thirty-two teachers responded to the questionnaire with 137 suggestions for dealing with the withdrawn child.

The question arises, are the 32 teachers who responded to this questionnaire similar in important respects to the 40 who did not respond? If we are to make generalizations about teachers from the results of this study, we must have some assurance that the teachers who responded are representative of other first and second grade teachers. According to t-tests, the mean ages of the responders and the non-responders are not significantly different, nor are there significant differences in years of experience. Performance ratings by supervisors were not markedly different for the two groups. A chi-square test of the distributions of the two groups according to amount of formal training was not significant, although it closely approached significance at the .05 level, the responding group having a slightly higher academic attainment. There are, therefore, no statistically significant differences in the above-

mentioned respects between the responders and the non-responders.

Although each technique was aimed *ultimately* at bringing the withdrawn child into better social contact with his peers and his teacher, the techniques could be classified according to certain sub-goals which were vital to the attainment of the overall goal of bringing the withdrawn child into closer contact with the people about him. There were seven of these sub-goals or intermediate objectives (including a "miscellaneous" category). They are listed below in the order of frequency with which they were mentioned:

1. *Develop the child's confidence in himself; provide ego support and enhance the child's self-concept.* Seventy-six of the 137 suggestions, or 55 percent of the total, were placed in this category. Because such a large number of the responses were included in this classification, this category was broken down into sub-categories as follows:
 - (a) *Directly praise the child for things he has done, taking every opportunity to give legitimate praise.* Several teachers reported that they would even praise a child for such behavior as "being such a good restler."
 - (b) *Give the child recognition.* Although this is closely allied with the giving of direct praise as described above, it involves a somewhat different class of activities. For example, one teacher made a special point of talking "to" a withdrawn boy by looking directly at him now and then during group sessions. Other teachers would call on him first to be "It" in a game, and others might call the group he is in by his name, i.e., "Tom's group."
 - (c) *Confer some responsibility on the child.* "Confer" is used advisedly, as against "impose." Emphasis was placed on the fact that this responsibility should involve tasks which the child perceives as real and important.
 - (d) *Find areas or activities in which the child feels secure enough to participate.* Some children were able to talk relatively freely about their families when questioned. Some children first participated in group activities when they described their pets at home or were asked to bring them to school. Other children were drawn out through art activities.
 - (e) *Ask the child for suggestions and advice in areas where he is able to be helpful.* Teacher-pupil planning was described as one activity which was often helpful in getting a child to participate.
 - (f) *Inform the child of the progress he is making.* Although this is closely related, again, to the direct praise described in (a) above, it is somewhat different in that it is a more objective description by the teacher of the progress that the child is making. She points out, for example, that he is able to do certain things which he was not able to do before. This may also involve sending evidence of good work home to the parents.

(g) *Help the child when he needs it, and not only when he asks for it.*

If the teacher is perceptive enough to know when the child needs help, she may be able to help him avoid many traumatic failure experiences.

- *Manipulate the environment to encourage the child's contact with his peers.* Some variation of this approach was advocated in 13 percent of the responses. Some teachers make a point of placing the withdrawn child in group activities with friendly children. He may be seated near outgoing, friendly boys and girls. The child is often placed in a very small group to make it easier for him to communicate with the others in the group. Some teachers directly encourage other children to play with the withdrawn child.
3. *Wean the child gently away from withdrawal and toward participation* (10 percent of total suggestions). The child is protected from traumatization, from being pushed faster than he feels capable of moving in the direction of participation with others. Thus, the child is allowed to participate in groups first, where he is able to remain relatively anonymous and yet participate in the group. Later, when the teacher feels he is ready for individual participation, he may be encouraged to perform individually. If individual participation is required by the activity at a particular time in class, one teacher's technique is to "wait until others have made mistakes before asking him." Some teachers protect the child against the ridicule and teasing of his classmates. Another technique for "gentle weaning" is to start the child on activity which is primarily or solely physical. It is usually some activity which he can do by himself and which does not at first require communication with others. It amounts to starting the child with some form of "parallel play" and bringing him along from that stage of development. Later on, he is given activities which require the help of one other child, and through this gradual process the child is brought into active communication and participation with the group.
4. *Help the child to understand his need to participate and share with others.* The specific technique most frequently used here was to talk directly with the child, pointing out how much more fun it would be for him if he were to join the others. Nine percent of the suggestions were in this area.
5. *Develop feelings of security in the classroom, helping the child to feel "at home" with the teacher and with other children.* This may involve conversing with the child about things with which he is familiar, directly assuring him that he is needed and loved by the teacher and the rest of the class, smiling, and providing enough freedom within the room so that the child does not feel that he is hemmed in by regulations and restrictions. One teacher reported that she had taken a withdrawn child home with her for dinner and the evening to help the child develop feelings of security with the teacher in the classroom.
6. *Set a pattern of relaxed calmness in the classroom.* Four of the 137 suggestions were classified in this group. All four of these suggestions were given by one teacher, and included "using soft but clear voice tones" and "moving at a moderate speed."
7. *Miscellaneous suggestions.* These are responses which did not appear to be classifiable in any of the other categories, and include the fol-

lowing: Provide a good example of acceptance of, and communication with, the withdrawn child; set standards of achievement within the child's capability and keep the child challenged; work from an understanding of the home situation; suggest to the family that the child have a physical examination.

The material presented above may be said to represent the thinking of thirty-two first and second grade teachers about how best to deal with the withdrawn child. We have no adequate evidence as to whether or not the thinking which is presented in this study is transformed into effective action. The teachers' responses to this questionnaire tell us what they know about how to deal most effectively with the withdrawn child. Evidence that at least some of the teachers are practicing the techniques which they describe may be derived from the fact that many of the teachers, in reporting their techniques, described specific cases in which they were used, frequently giving the name of the child.

The results of this study have some interesting implications with regard to the mechanism of withdrawal in children at the first and second grade levels. We must consider, first, that these suggestions for handling the withdrawn child come from people who are practitioners dealing with "normal" children in a "normal" setting. That is, these are not children who have been referred to a hospital or child guidance clinic, and their withdrawal cannot be considered pathological. With most of the children, the withdrawal appears to be an adjustment mechanism which is amenable to change without prolonged and intensive psychotherapy. As indicated above, 55 percent of the suggestions could be classified as "ego-supportive," but many other suggestions which were not classified in this category nevertheless had a strong element of ego-support in them. From this, we may conclude that the teachers in general feel that the withdrawn child needs most to develop confidence, or, in other words, to develop a different and more flattering self-concept. The implicit reasoning behind the techniques used by the majority of the teachers appears to be that the child withdraws because he feels inferior in the kinds of activities taking place in the classroom. There is a need in every child to maintain a favorable self-concept, and the withdrawal is a protective mechanism to prevent failure and a

consequent lowering of the self-concept. Thus, by improving the child's self-concept (increasing his confidence in himself), the teacher encourages the child to participate with other children and also makes him more able to tolerate failure. The child who is not severely traumatized by failure in a group situation is able to participate, and in the process is likely to achieve some successes. This is why children who are once brought into participation with the group, under the guidance of a supportive adult, are usually able to continue under their own power as members of the group. The extent to which ego-support is recognized as a necessary element in the socialization of the withdrawn child is indicated by the fact that only three out of the thirty-two reporting teachers did *not* report some kind of ego-supportive technique.

SUMMARY

This study has reported the results of a questionnaire sent out to thirty-two first and second grade teachers concerning techniques for helping the withdrawn child. The 137 suggestions gleaned from the responses were classified according to seven categories of techniques. It was found that a majority of the suggestions involved providing ego-support to the child and enhancing his own self-concept. Some implications of this study for the mechanism of withdrawal in young school-age children are suggested.

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HELPLESS—NOT HOPELESS

JUDITH CELLER¹

The spirit of a man will sustain his infirmity;
but a broken spirit who can bear?

Proverbs, XVIII, 14

I AM a cerebral palsy—a severe cerebral palsy. Physically, I am totally helpless, but mentally and emotionally I am completely normal.

How does a severely handicapped person with a normal brain adjust to the world? Let's face it—you have to cut the cloth to fit the pattern. Adjustment can be made only within the framework of the material at hand. In my case, the material at hand was very limited. Did you ever smash an electric light bulb? That's what happened in my brain. The cells of locomotion were completely shattered as a result of an injury at birth. An injury of this sort causes spasticity in the muscles of the body. Spasticity simply means the involuntary contracting of the muscles because the muscles do not receive the nerve impulses correctly from the brain. The impulses come too fast—a lot of short irregular ones, instead of one long even one. Open and close your hand several times very quickly. Now imagine your hand doing this of itself. This is what happened to me—not in just one hand, but throughout my whole body.

Another part of the overall physical picture which has a social aspect is a severe speech defect. I said before that my handicap was a physical one, and not a mental one. Yet speech, my only communication with the outside world, falls in the realm of the physical. So in order to express myself, I have had to overcome this all-important impairment.

You will notice that I have used the past tense, because to a great extent I have not only overcome my speech defect, but I have made great strides in improving my general condition as well. That is, within the realm of my possibilities. The cerebral palsied person that one sees walking around today is a hemiplegiac, which means that two lobes of the

¹ In collaboration with Ronnie Falick.

brain have been injured. In my case, fate decided to do a thorough job. Four lobes were affected. Until I was about seven, I was almost vegetative; I had absolutely no control of my body. My arms and legs flew around in the air and I couldn't sit up without being propped on all sides. When I tried to hold my head up it jerked and flopped from side to side. My speech was an unintelligible kind of "grongeling," as we called it—harsh, low guttural sounds that only my mother and nurse could barely understand.

Today, as a result of intensive training, I am able to sit quietly in my wheelchair. I can hold my body and head erect. My pronunciation is good and I speak in a pleasant voice. Anyone who takes the trouble to listen carefully can understand me.

When I look back upon my life, two seemingly contrary themes emerge. One is an increasing feeling of isolation and withdrawal that comes with an ever-growing awareness of my handicap. The other is an intense desire to overcome this feeling of isolation, and to participate as much as possible in a normal life.

As a child, I was hardly aware of my handicap. I lived with my mother and father and sister in a brownstone house in a pleasant section of Brooklyn. It was pleasant because everybody knew everybody else. We said "good morning" to the letter-carrier; we knew the street-cleaner; and the men tipped their hats and said "good evening" when they came home from work. All the children played and grew up together. They never taunted me nor made fun of me, and no one ever pointed and said, "Look at her—she's a cripple." I guess that was because their mothers brought them as small children to play in our yard, and as they grew older they gravitated there. My yard was the focal point of the whole neighborhood, and I was always in the middle of everything that was going on. When the kids jumped rope, I was always the "ender." Every time the rope fell out of my hand, which was often, they would pick it up and say, "O, Judy, you've dropped it again," and then hold the rope until I could grasp it. We used to play hide-and-go-seek. The one who was "it" would put his head in my lap and I was to see that he didn't peek. While I was counting, I carefully took notice of where

each one hid. I know that I had more fun than the other children. Why? You know how it is when you watch a murder mystery: the killer is lurking behind the door and the detective is just about to open it—you're dying to yell "watch out!" That's what happened to me when the child who was "it" approached the spot where one of the others was hidden. I was in a frenzy of excitement, and it took everything I had not to give it away.

My yard was the neighborhood playground, but there were times when the children didn't come—that is, all except Dorothy. Dorothy had a great deal to do with making my life normal. Very often the blind will say that another person is their eyes. Well, Dorothy was my hands and legs. She moved into our neighborhood when I was six. She was a year younger. Luckily for me, children's friendships seem to spring up without regard for the petty differences to which grown-ups attach so much importance. Dorothy, like most of the other children on the block, differed from me in religious as well as economic background. I am Jewish, she is Catholic; and my family was considered well-to-do in comparison with hers. Still, we were the best of friends. We used to play ball together, or rather Dorothy played for both of us. She would bounce the ball for herself, then, when she missed, she would play my turn. Surprisingly enough, I even won once in a while.

There were many games that we played by ourselves that nobody else could share. One stands out because it went on for years. In fact, it went on until we reached our twenties. We called it "The Gang," because we acted out the parts of imaginary characters who always palled around together. Of course, it was highly indicative of our secret desires. Dorothy was the glamour girl, replete with furs and riches; I was the smartly suited and independent career woman who always made just enough to get along on. Contrary to the soap operas and comic strips, however, *our* characters grew older and their children grew up.

Don't get the impression that Dorothy and I got along perfectly. We fought like any other two kids would fight. Often and well. My mother tells the story about the time when a horrified neighbor rushed into the house to report that Doro-

thy was hitting Judy. He was sure that this would end all friendship between the angelic little invalid and the nasty girl next door. He was completely floored when a very unperturbed mother replied, "What did Judy do first?" And I guarantee that little angelic Judy *did* do something first.

The attitude of Dorothy and the other children was a direct reflection of the attitude of my mother and father. They decided from the beginning to treat me as normally as possible, and so they did. My life within the family circle was like that of any other child. I was scolded when I deserved it; I was praised when I merited it; I was encouraged when I needed it. I realize now that although they worked together, each played a different role in my life. In my mind, the word "Daddy," is synonymous with the word "fun." Because Daddy is such a kind, gentle person, it must have hurt him terribly when he realized that his Judy would always be an invalid. I'm not supposed to know this, but I've always felt it intuitively. Perhaps this is why he comes home cheerful and joking at the end of a tiring and sometimes discouraging day. Daddy was never too tired to give me a piggy-back ride—our favorite game. When bedtime came, Daddy was my white charger who galloped up the stairs with me on his back. We would hide in my parents' room while my mother looked for us. First she would look in my room, and when she couldn't find us there she would say loudly enough for me to hear, "Now where can they be?" As though she didn't know. In the meantime I'd be giggling while Daddy tried to hush me. Then as my mother came down the hall to look in her room, we would sneak into my room through another passageway. By the time my mother found us, I was tucked snugly into bed and insisting that I'd been there all the time. The more we played it, the better I liked it. The repetition never seemed to diminish the fun or suspense for me.

Daddy and I had lots of rollicking times together—a good old-fashioned rough and tumble session was my greatest delight. Daddy never missed an opportunity to give me a happy time, and because he is such an adaptable person and gets fun out of simple things I know he enjoyed these times as much as I.

Unfortunately, these happy times had to be few and far between. Daddy is a Congressman, and his duties keep him

away from home a great deal. This meant that my actual upbringing fell to Mother. All mothers have the responsibility of providing for the particular needs of their children—seeing that they eat the right food, get to bed on time, and do their homework. But mine realized the need of establishing a pattern of behavior towards me which could be followed by those around me. It would have been easy for Mother to fall into the pitfall of overprotecting her helpless child. But she understood that even such as I would have to face the world and cope with its problems. So Mother treated me as normally as possible, and the others in the family followed suit. My favorite dessert wasn't served more frequently than anyone else's. I had to eat my lima beans even though I hated them—they were good for me. I had to wear long cotton stockings in the winter time. And I had to go out in the fresh air, whether I wanted to or not, and what's more I had to stay out the allotted time. I knew that all my arguments or persuasions to the contrary would not prevail.

The most important and wonderful thing was the influences and people Mother brought into my life. As I couldn't go out and find them for myself, she had to bring them to me. That is why I call her my stage manager. She introduced the people onto the stage of my life, and then, as do all good stage managers, let them perform in their own particular way.

When I was seven, my mother brought two people into my life who have had a greater influence over me than any of the others I have ever known. One of them is my nurse, Fraulein. I have been fortunate in having the same nurse for twenty-three years. When my parents have to leave me for any length of time, they can go with never a worry as to my care. Fraulein is always there. Not only does she take perfect physical care of me, but she has been like a mother to me. When I want to talk something over, Fraulein always listens; when I have a problem, Fraulein always understands.

Fraulein had many little ways of entertaining me. She told me stories about a most unusual dog she had in Germany that could talk, cook, clean, and take care of the house. I would look up at her with an incredulous expression and ask, "Have you really got a dog like that?" "But of course," was the reply.

Fraulein used to tell me about her childhood and teach me the little folksongs that she had learned. At Christmas time she would tell me about the Christmases she knew in Germany; how they decorated their trees with popcorn and real candles. Today I still remember the carols that she taught me to sing in German. Through Fraulein's reminiscences, I came to understand and appreciate the character of the people, and I think that is the reason I feel so strongly inclined toward German music and literature.

As I said before, Mother brought two people into my life when I was seven. The second person was Leonie. At the time, Mother felt I needed training in coordination and speech. My orthopedist recommended Leonie as a fine physical and speech therapist. It was she who brought about my development from a vegetative being to what I am today.

This was done with intensive training, kindness, compassion, and patience. Consummate patience is absolutely necessary for this type of work. The primary requisite in remedial work such as I required is to learn relaxation—a difficult task. The more I relaxed the less spastic my muscles were. Only through relaxation can coordination be taught. When one railroad track is damaged, the trains that run on that track must be rerouted. As many of my nerve pathways, or tracks, have been damaged, the nerve impulses have to be sent along other pathways. Leonie accomplished this first with passive, then with active exercise. Suppose that the task was learning to flex my arm. First Leonie moved my arm, until after many repetitions, I got the feel of the movement. Then I took over and tried to duplicate the movement I had just felt. I might do it once and then lose it, and so Leonie would repeat the passive phase. The new pathway was established when I had nailed it down to the point where I could do it at will.

The same procedure was followed with my speech. Naturally, for practical purposes, we attacked the problem of pronunciation first and when I had some mastery over this, we went on to the more difficult task of voice training. I was tone deaf. Many similar tones sounded identical to me, and therefore I had to learn to hear the difference between them, not only in Leonie's voice, but in my own. Once I could distinguish between them I could use the sounds properly in my

speech. As a dancer requires rhythm to perform smoothly, so I had to learn rhythm to coordinate speech and control movement.

I'm sure you realize that such people as I have psychological problems that are closely related to the physical aspect of their handicap. Here Leonie's training in psychology was of immeasurable importance. She explained to me that although my desires were like any person's, they had to be sublimated because of my condition. She helped me to overcome the self-consciousness and uneasiness that I felt when I jiggled around and grimaced in public. When I entered a restaurant, I hoped I could sit at a table against the wall because I knew I didn't eat properly and I felt self-conscious and uncomfortable when others watched me. Leonie explained to me that most people feel conspicuous when all eyes are upon them, and that this feeling was by no means peculiar to me.

Leonie did more than just teach me. She showed me a way of life—a way to live with my handicap. By talking about my handicap as naturally as you would about the weather, she got me to look upon my disability, not as something to be ashamed of and hidden away in a corner, but a condition that I had to accept and live with.

As a small child I was painfully timid, perhaps because I was afraid that someone might take advantage of my helplessness. Through the years, Leonie showed me how to stand up for my rights, while at the same time she made me realize that I was not the whole "cheese"—that I was one member of the family and had to fit into the life of the family.

All individuals are sensitive. I am no exception. People have unwittingly hurt me so many times in so many ways that it would be impossible to recount them. The ambulant do strange things. Often I have gone to Leonie with these hurts, and because of the empathy that exists between us, I was finally able to understand the immortal phrase, "Forgive them, for they know not what they do."

Today, as a result of the efforts of the United Cerebral Palsy Societies, the New York City Board of Education has established special classes in the public schools for cerebral palsied children. When I became of school age, educators, doctors, and even parents were just becoming aware that

some C.P.'s had mentality, and that with proper training they could become useful members of the community.

Home instruction for the handicapped had just been established by the Board of Education. A teacher was sent to the child's home for one and a half hours two or three times a week. Before the child could get a teacher, she had to be interviewed in order to ascertain whether education was indicated. My interview was my first encounter with harsh reality. Imagine a spastic child, who becomes ten times more spastic when she is nervous, coming for her first interview. True, my arms and legs flew in all directions, and it was almost impossible for a stranger to understand me, but according to my mother, there was always an intelligent expression in my eyes.

My mother wheeled me into the room. The interviewer looked up from her desk, took one swift glance at me, and with a wave of her hand, said, "No mentality. She can't have a teacher."

Luckily for me, my parents were intelligent and determined enough not to accept this arbitrary verdict, but appealed to someone higher in authority. Finally, I was granted my teacher. But what about those other children who met with the same heart-breaking experience?

Home instruction at best cannot compare with going to school. I had only three lessons a week, each lesson lasting one and one half hours. It is true that four and a half hours a week is hardly time enough for anyone to learn the three R's. It is also true that weak eyes and poor coordination made me a slow reader. But, in addition to these, I was lazy. Reading was hard, so why make the effort? To make things easier for me, when I first began to learn history and geography my teacher gave me a little book with questions and answers along with the textbook. I skimmed through the textbook and relied on memorizing the little book. The result was that I never learned to study from a textbook.

I could not take exams, at least, not in the beginning. At the mere thought of one, I would go to pieces. Gradually, however, I was able to take informal oral ones, but even then, in a spelling test, for example, my teacher would pick out those words that I was sure to know. As luck would have it,

she became ill on the very day that I was to take my final examination. A substitute teacher was sent, and she picked words at random. I was terrified. Spelling was my worst subject. I got 48. The passing mark was 65.

In spite of my trials and tribulations, and how amusing they seem now, I managed to graduate. Daddy was the main speaker at the exercises, and it was a proud and happy moment when he handed me my diploma.

It's too bad that one has to grow up, because with growing up come problems. Gradually, almost imperceptibly at first, I began to have a sense of isolation. As I grew older, this feeling took on momentum, until now I feel it most keenly. This article is an attempt to break through my isolation, but I am getting ahead of my story.

My high school days were just a continuation of grammar school as far as *lessons* were concerned. But it was in the social aspect of my life that I began to feel my isolation. Adolescence is primarily a period of giggling and romantic nonsense. Dorothy and I continued with our game, but it took on a romantic aspect. We were both "in love" with Nelson Eddy and so we incorporated him into our game. On Saturday afternoons we would play Nelson Eddy records, and I still find myself getting nostalgic when I hear "Do You Remember?" from "Maytime." Dorothy would dance. I couldn't. Not being able to walk alone didn't bother me. I could be wheeled to wherever I wanted to go. But dancing, ah, that was romantic, and nobody could do it for me. Dorothy could play ball for me, but dance for me she could not.

If watching Dorothy dance was hard for me, you can imagine how left out I felt when she began to go out with boys. Sunday mornings she would tell me about her Saturday night dates. This always produced a conflict within me. On the one hand, I wanted to hear all about it, because through her I could experience, at least in part, the thrill and excitement of a date. On the other hand, I felt miserable after she went home because I could never really know what it was like to go out with a boy. It's one thing to listen to someone talk about experiences—I was carried along by the good times that Dorothy described—but it's quite another matter to brood over them later. It was then that I really felt out of things.

However, a few years later, a friend of ours did introduce me to a young man who had cerebral palsy. He was getting his Ph.D., and since I was taking college courses, she thought we would have a great deal in common. Because I had read so many love stories, I formed a mental picture of a "dream boy"—tall, blond, and handsome. Harry was so different from my romanticized concept that my heart fell when I saw him. To cap the climax, his hand was wet and clammy when he shook mine. Then and there I made up my mind that I would have none of him. Every woman has one regret in her life. This was mine. It may have been all moonlight and roses then, but now that I am ten years older I realize that it is not the exterior that counts. Love, marriage, children—these are the things that make life worthwhile—this is the banquet of life. A banquet I cannot partake of. I can only watch it as though through a window.

Religion is an integral part of almost everyone's life. The only religious experience I had had was a little German bedtime prayer Fraulein taught me and the prayer that my mother said over the Sabbath bread. When I was fourteen, I decided that I wanted to be confirmed. My mother agreed, and engaged a rabbi, and for two years he taught me Jewish customs and traditions. A few months before confirmation, our family rabbi suggested that I attend his confirmation class. I was very excited, because for the first time I had to buy a dress for a special occasion, and not just because I needed it. Then, too, this was my first experience with a group of people of my own faith. Once again I felt strange and isolated—this time an isolation that had nothing to do with my handicap. To add to my distress, they were discussing ethics, and I had no idea what the word meant.

Confirmation day followed the usual pattern—the services, the party, the presents. The outstanding moment came when the rabbi stepped down from the pulpit, and placing his hand on my bowed head, said, "May God bless you and keep you."

If there was one person who more than any other helped me to overcome my isolation, it was Dorothy—Dorothy with her gaiety and her wonderful capacity for enjoying people. When I was about eighteen I was asked to join the sorority to which my sister belonged. I went through the usual feel-

ings of pride, terror, and joy when I was asked, pledged, and finally initiated. At first Fraulein took me to the meetings. But one day when Fraulein wasn't feeling well, Dorothy went along. Except for the fact that the chauffeur drove us and called for us, Dorothy and I were just like any other two girls going out on a Sunday afternoon. It gave me a sense of complete freedom, because I could be with people my own age without having an older person along. My self-consciousness fell away. I usually had been too self-conscious to eat at meetings, but this time, before I had a chance to protest, Dorothy popped a big cookie into my mouth, and jokingly said, "Now don't go and choke on me." I laughed, the girls around us laughed, and the tension was broken. The afternoon was such a huge success that my mother asked Dorothy whether she would like to go with me every week. And so began a series of happy times that lasted for two years.

We went to several cocktail parties and a dance or two, but the occasion I remember best is my first cocktail party. Dorothy and I, dressed up in our party finery, came downstairs for inspection. My mother looked us over carefully and decided that, yes, we would do. Daddy, with a sly grin, asked us if we had enough money to get drunk on, and slipped ten dollars into my hand.

When we arrived at the Waldorf, we discovered that my wheelchair would not go through the revolving door. What to do! Dorothy, with her usual pluck, marched straight off to the manager, and together they decided that I should go in by way of the kitchen. And so, in our silks and satins, we sailed gaily by the pots of stew, tons of peeled onions, and heads of lettuce.

Towards the end of the party, three of the girls decided that they would go to a cafeteria for a bite to eat. I glanced at Dorothy with a look that said, "How I wish we could go too." As if she read my thoughts, Dorothy said, "Let's go." You can't imagine what a thrill it was for me to have Dorothy call home and casually tell Fraulein that I wouldn't be home for dinner. At the cafeteria, I had a terrible time getting down a dry cream cheese sandwich, but who cared!—I was having fun.

When I grew too old for the sorority, I joined Hadassah, a

women's Zionist organization. Dorothy came along, and so they asked her to join. As far as I know, Dorothy was the only Christian who belonged to Hadassah.

I said before that I went to dances. Would you be surprised if you saw a chair-bound person at a dance? Well, such a thought never entered my mind. I felt myself a participant at these dances. When the music stopped, Dorothy would bring the boy she danced with over to meet me, and a group of boys and girls would gather round. Sometimes, when the music started, one girl would ask me to hold her purse, and another to keep an eye on her coat. I couldn't quite decide whether I felt like a hat-check girl or a dowager mother. One time, when Dorothy had left the room for a moment, she returned to find me busily chatting with a soldier. Her first words after we left were, "My goodness, I turn my back for a minute and look what happens. You pick up a soldier."

Suddenly and without warning, the dances, the cocktail parties, the "gang"—all stopped. Dorothy got married. There usually is a barrier between a married woman and an unmarried one. Dorothy and I no longer had anything in common. We drifted apart as though all that we had meant to one another had never existed. I didn't hear from her for months, and when she did come she was here in body only. It broke my heart. She had been so much a part of every phase of my life that after she left I didn't know how to pick up the pieces. I realize now that she didn't mean to hurt me—she was just thoughtless. The new Dorothy is a stranger to me; I will always love the old Dorothy.

Until now I had gone to Leonie with problems relating to my handicap. When she confided to me that she had experienced a disappointment such as mine, I turned to her as a friend. She said that the way to adjust to a loss was not to dwell on it, but to put other things in its place. She suggested that I take up music, so that I could enjoy going to concerts and opera. Daddy loved music, and my parents were seasoned opera goers. Leonie's idea fitted in well. Saturday night is always a big night during the opera season. Eating dinner in Manhattan and attending the performance is a bit of glamour that I look forward to all week.

I also wanted some social activity that would bring me into

contact with other people, with whom I could participate in an exchange of ideas. I joined an evening branch of the National Council of Jewish Women, and was later elected to the board of directors. I am now the chairman of the world affairs discussion group, and together with my co-chairman plan our monthly discussions. Council has performed an immeasurable service for me, for it was here that I really developed poise. In the beginning I was too frightened to say a word. Gradually, first at the board meetings and then at larger and larger gatherings, I found my tongue. Now, at least at board meetings, I cackle so much that I am often told I am speaking out of order. Of the four meetings a month, I enjoy the board meetings best. Because it is a small group, the women let their hair down, and I have a chance to savor stories that I would not otherwise hear.

If they have the determination to overcome obstacles, severely handicapped persons can have a college education *at home*. I did. It came about quite by accident.

It was a foregone conclusion that when I graduated from high school I would go on to college. Brooklyn College arranged for me to take their entrance examination privately, and on the basis of this I was accepted as a limited matriculated student. At an interview with the dean of students it was decided that I take two subjects—English composition and Spanish. I elected Spanish because I had studied it in high school and wanted to become a translator. I attended classes for two weeks, a different person taking me each day—once Fraulein, once Mother, once Leonie. Naturally, each of them took notes differently, and when I tried to review the day's lesson I couldn't follow their thought. In addition, I had never before been in a classroom, and found it difficult to learn there. To add to my difficulties, the English course necessitated my doing work in the library. I couldn't do it myself, and there was no one to do it for me. As a solution, we decided to ask a girl who was majoring in Spanish to take notes for me and help with my library work. Despite this help, going to college proved to be too much. In the meantime, I learned more from Helen, the girl who was helping me, than I did in class. So we decided that I should have my lessons at home. Helen would teach me Spanish, and I arranged

with the English department to have one of its students give me lessons in composition. I had to go to school to make these arrangements, and since I was already there I decided to attend the last twenty minutes of my English class. As I entered, I found the class discussing the Cliveden Set, allegedly a Nazi faction in England—*my* composition! Then and there I wanted to stay in college, but of course this was impossible.

When I learned that Brooklyn College would not give credit for courses taken at home, I was terribly disappointed at not being able to get my degree. Daddy, sensing that I was unhappy, had a long talk with me regarding this subject. Most of what he said I don't remember now, but two things remained. Although I would not receive my diploma, he said, I was getting my education. That's what counted. Secondly, Daddy told me that he had misplaced *his* diploma many years ago. I thought to myself, "If he can have so successful a career without an official piece of paper, why did I need one?" And so began my college work at home.

Believing that I could earn a living either as a translator or in some other capacity, I began by taking the regular college courses. Later it became apparent, however, that I was physically unable to get a job. Needless to say, it was a blow to me but one to which I had to reconcile myself. The thing to do was to cultivate my mind. The chair-bound are bystanders. They have more time to think than those who actively participate. I began to deviate from the required curriculum and take subjects that interested me. I went along at my own pace, dwelling on those aspects that held particular appeal. In this way I believe I have had a more thorough education than most college graduates. My motivation for learning was my own interest and not an end-term grade. I took, among other things, psychology, classics, and history. I was fascinated by the political implications of history because politics have always been an important part of our family life.

The study of music was a very important part of my education. At the time of Leonie's suggestion that I go to the opera and concerts I decided to take music appreciation. This would enable me to understand better what I had heard. The

method of study was simple. I got recordings of classical compositions from the public library and played them until I knew the themes. When my teacher came, she would show me how they were developed. If I couldn't hear them in orchestration, she would play them on the piano. We found that I could not hear the difference between major and minor, and so I added ear-training to my music lessons. Since Leonie was teaching me to distinguish sounds, the ear-training was of help to her.

You may wonder what types of girls came to teach me. As far as the actual teaching was concerned, I had good, bad, and indifferent. As far as personalities were concerned, I had quite a variety, from every walk of life. Some stayed exactly the allotted time and thought of it simply as a job. Others took a personal interest and often stayed overtime. It was those who took a personal interest who became my friends—my only friends after Dorothy left. Each one's marriage and preoccupation with bringing up a family meant another parting of the ways. There never seemed time to visit me, and when I visited them I felt like a fifth wheel on the wagon. This lack of friends was a social isolation about which I could do nothing. There is no substitute for friends. My mother consoled me with the thought that when their children were older my friends would have more time to spend with me. In the meantime, I would just have to wait.

From time to time I am forced into a period of inactivity as a result of a hip injury. For years I sat with my entire weight on my right side, not heeding Leonie's warning to watch my posture. One night at a concert, in an effort to see over a woman's hat, I exaggerated this position to such an extent that the next morning I couldn't move. I had strained the muscles of my hip to the point where they were literally worn out. My condition is such that while it does improve with time and proper treatment, I get recurring attacks which put me flat on my back again. Then I must watch a pattern of revolt, a propensity to self-pity, lest I become a dreary soul and boresome.

At first people came to see me, but soon growing accustomed to the idea of my being in bed, they no longer bothered to come. My cousins, Helen and Alfred, were the exceptions.

They have been coming to see me every Friday night since I hurt my hip. Alfred tells me jokes, asks me riddles, and tests my knowledge. When I give an answer with which he doesn't agree, we have long involved arguments which are settled only by bringing out the dictionary or the encyclopedia. Sometimes Alfred doesn't even believe them.

The first winter, realizing how despondent I was, they thought I'd be happier if I could occupy my time with running a business. They gave a great deal of consideration to finding just the right type of business—one in which I could actively participate. They hit upon the mail-order stocking business. Helen and I became partners in the Celbest Company. I supplied the capital from my personal savings; she does the footwork. On their weekly visits we discuss policy and plan letters of advertisement. While I was never to get a job, I do have a business that provides me with a small income and a taste of self-sufficiency. What a wonderful feeling when Helen laid the first dividend before me! I didn't know whether to laugh or cry. I spent the entire night awake planning a thousand and one things to do with the money. By morning I had decided to give Daddy a surprise. He wouldn't have to buy my opera ticket that season—I would buy my own.

Celbest provides me with something besides dividends, something less tangible but more important—a sense of equality. No one has ever demanded thanks for things that must be done for me. Although I am genuinely grateful, this gratitude brings with it a feeling of obligation and dependency. The partnership gives me a feeling of complete equality. I can agree or disagree as I see fit, with all the privileges that go with being a partner.

I have found substitutes for each type of isolation. Substitutes never completely take the place of the real thing. I felt that my life lacked spiritual meaning. At last I came to realize there is something I can do—I can write. Only through helping others can our lives gain full meaning. And so this article. I have tried to give you a better understanding of how it feels to be cerebral palsied. This is my spiritual outlet. I am determined. *I will write.*

THE VOICE OF THE PATIENTS: AN EARLY REPORT*

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SEVERAL months ago at a staff meeting of the clinical services department of Anna (Ill.) State Hospital, there arose some differences of opinion concerning the most proper and therapeutic manner of addressing patients. It was suggested that the patients themselves might be consulted in the matter. The issue broadened into an awareness that a direct assessment of patients' opinions in matters which would seem to have a bearing on their institutional management might be a worthy supplement to speculations by the staff.

Notice of a convocation for patients was transmitted through the employees and the patients' publication, *The Anna-lyst*. A psychologist and an activities therapist were appointed to act as technical advisors to the group and as staff observers. The first three meetings were disappointing in that there was an average of only seven patients present. At the suggestion of the advisors, the group nominated a temporary chairman who proceeded to select a representative from each ward (except for particular wards, *e.g.*, TB, infirmary, senile, etc.). However, any patient with a grounds pass was welcome to attend and to participate equally with the appointed representatives. In the four following meetings the attendance has increased to an average of about 30.

From the point of view of the staff, one of the primary purposes of the group was that the patients would have an organization for voicing opinions and making suggestions concerning their welfare, for receiving and transmitting information. It was anticipated that the group would take on aspects of a psychotherapeutic group. The group was advised of the former expectation of the staff but was told that it might serve any purposes it saw fit.

As might be anticipated, much of the activity of the group

* The Voice of the Patients is the name that was adopted by the group at Anna State Hospital, Anna, Ill.

consists of individual petitions for release or complaint of unjust commitment or mistreatment. The group is well attended by paranoid types and is largely dominated by them in this respect. There is an historical condition which contributes heavily to the tendency to voice these feelings: many patients come to the hospital against their will. Many are brought without knowing that they are being taken to a mental hospital. Many are admitted under deceptive pretenses such as promises that they will have to remain only a short and specified time. Traditionally, the hospital has been passive in correcting misapprehensions of this sort and in explaining why the patient was considered to be in need of hospitalization. It is rare that the patient has been told by the staff what in his behavior was a problem and hence there is little to correct the patient's lack of understanding as to why he is in the hospital. It appears that there is a need to investigate means of communicating to the patient the need for his hospitalization. It follows logically that the patient is incapable of orienting himself in a constructive way to his problematic behavior when his problems are not clarified.

To perform this function, it is necessary to be able to evaluate the patient's level of comprehension. One must be sufficiently comfortable personally so that he will neither hide behind "the facts" defensively nor attack the patient with them out of counter hostile motivation.

It is the policy of the advisors to permit free verbalization of feelings when the patients complain about their commitment and retention in the hospital. The advisors accept the hostility that accompanies such complaints and take supportive and permissive attitudes toward all comments. Other procedures are to elicit other patients' similar experiences and feelings. At times it becomes necessary to prevent other members of the group from suppressing a member: the advisors operate on the principle that freedom of expression—on any issue—must be preserved at almost all costs. Thus, individual complaints of unjust commitment, mistreatment, etc., are handled as they might be in a psychotherapeutic interview unless the patient begins to become embarrassed or unless the therapists concede that they do not have the facts at that time. The afternoon following the meeting is set aside by the psychologist to in-

investigate such matters both for providing factual information to the patient and also for general psychotherapeutic advantage.

Where possible, any complaint or comment is attended to for its face value or its positive aspects. This approach coupled with the practice of referring thoughts and feelings to the group for comments makes it possible to elicit a consensus of the group's feelings. These are formulated by the chairman as resolutions or recommendations which are voted upon. By the vote of the group, the activities therapist is functioning as secretary, temporarily. The minutes of the meetings are not recorded *verbatim* but accent the positive (that is, permitting of constructive action) aspects of comments, complaints, or suggestions. These minutes are abstracted, and the resolutions and suggestions are sent to the superintendent who reads them at the meeting of the clinical services staff where they are acted upon.

Thus far, the following opinions and recommendations have been communicated and have been carried into action by the staff or are being considered for action: The patients wish to be addressed as Mr., Miss, or Mrs., and not by their first names; they wish to be referred to as ladies, gentlemen, men, and women, rather than boys, girls, etc. They recommended uniforms for patients who have industrial assignments which are hard on clothing. They have requested supplies and permission to build various recreational facilities such as a skating rink and a tennis court.

Most of the patient's requests have concerned themselves with receiving information: They have asked for facts and figures on mental illness. This was met by a report by the psychologist concerning the admissions, readmissions, treatments, discharges, population, etc., for the nation, the state of Illinois, and Anna State Hospital. To answer a group of questions related to the hospital's action in placing patients extramurally, personal affairs outside of the hospital, etc., the chief social worker was invited to speak to the group. The superintendent attended a meeting in order to give official recognition, praise, and support to the group. He also answered questions about Department of Public Welfare directives and the mental health code.

The patients have also asked for a book of rules and regulations for patients and have expressed a desire for the rules and regulations of employee groups to be made available to them. Since the fourth meeting, a second psychologist has been participating as an observer and critic for the benefit of the two advisors. Various members of the staff have come to observe the group in action although such visitors must be cleared first by the two advisors and by the group; the latter has always approved such requests and there appears to have been no adverse affect upon the group's action.

This project appears to have been favorably received by both patients and staff. It is part of a program to facilitate the flow of information between staff and patients. In keeping with this general program, an attendant's advisory group is also in the early stages of development. These are two groups whose feelings and opinions are felt to be too much ignored by hospital staffs. The staff advisors for both of these groups attend the meeting of the clinical services staff and relay information to be considered in various actions.

It is felt that this program will compensate for the lack of knowledge of the thoughts and feelings of the patients and of the employees (attendants) who figure most significantly in their hospitalization and in their administrative psychiatry. Such information would appear to be vital to a realistically integrated clinical service.

A COMPARISON OF MOVEMENT OF FIRST ADMISSIONS TO SELECTED MICHIGAN STATE MENTAL HOSPITALS

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A CONSTANT and continuing interest has been shown by administrators and researchers in the field of mental illness in the analysis of the movement of mental hospital patients. Generally this type of analysis has been concerned with data based on state-wide or region-wide experience and has usually been restricted to governmental institutions. Of necessity, this type of analysis obscures whatever variation may exist within a given hospital system.

The present report constitutes an attempt to analyze, on a limited basis, differences in the change in status¹ of first admissions to selected state mental hospitals in Michigan for selected years. The diagnostic composition of the group of first admissions is the major variable considered in the comparison of specific installations. The general hypothesis is that differences in retention and/or discharge rates are related to differences in the diagnostic composition of the group of first admissions to the specific hospitals. A second variable which is considered is the socio-economic character of the area from which the first admissions are accepted and to which they presumably return—if and when they do return.

The report is divided into several sections. First, a brief description of the background of the research and of the methods used in establishing the categories for analysis and in selecting the specific hospitals to be analyzed.

Second, the analysis of the selected hospitals is an attempt to determine the relationship between inter-hospital variation in the diagnostic composition of first admissions and the sub-

¹ Status, as used in this report, refers to the location of first admissions 3.5 years after admission in terms of the movement categories; resident in the hospital, in family care, on convalescent status, discharged, or dead.

sequent change in status of first admissions. A second part of this section is concerned with a more precise analysis of the socio-economic characteristics of the geographic areas served by the hospitals.

Method of Analysis

This general approach was suggested by the data presented in a report prepared by the statistics and procedures section of the Department of Mental Health, and in discussion of the data with the head of the statistics and procedures section. This report indicated that there was considerable difference in the retention and discharge rates between hospitals when these rates were analyzed by two broad diagnostic categories. In a state hospital system which has no formal policy differences among the hospitals and which is staffed by psychiatric personnel, all of whom presumably use the same basis for diagnosis, treatment, and release, these differences cannot be explained on any readily apparent basis. Certain suggestions can be made in regard to these differences, and this report is an attempt to examine more closely one of the suggestions, namely, that differences in retention rates are a function of the diagnostic composition of the populations concerned. For example, if hospital A admits a greater proportion of patients diagnosed in categories which are characterized by a relatively high discharge rate than does hospital B, then it would be expected that the discharge rate of hospital A would be proportionately greater than that of hospital B.

In order to make this comparison possible, it is necessary to combine the numerous diagnostic categories used in a reporting system² into groups of categories which provide significant numbers of patients. Those diagnostic categories which exhibit similarities in the changes of status of patients are those which should be combined for an analysis of this type.

The diagnostic groups which form the basis of this analysis were derived from an examination of the changes in status of first admissions to all Michigan mental hospitals for the civil

² The classification used in Michigan is that in *Diagnostic and Statistical Manual Mental Disorders*, American Psychiatric Association, Mental Hospital Service, Washington, D. C., 1952.

insane from 1945 to 1950. The time period considered—because of state laws regarding parole—is 3.5 years after admission. A frequency distribution of all first admissions for the six-year period by specific diagnostic category and hospital status 3.5 years after admission was constructed. Diagnosis was the only variable considered in this classification; age, sex, race, etc., any or all of which may be of considerable importance in influencing movement, were ignored. The resultant classification is only indirectly related to psychiatric criteria.

Table 1 presents the diagnostic groupings which were derived on this basis.

Selection of Specific Hospitals for Analysis

The focus on the diagnostic composition of first admissions as a factor which may influence subsequent changes in the status of these first admissions suggests a comparison of those hospitals which differ most markedly in the status distribution of first admissions 3.5 years after admission. The hospitals are examined in order to determine whether these marked differences are associated with proportionate differences in the diagnostic composition of the first admissions.

Since the other major aspect of the analysis is concerned with the relationship between changes in status of first admissions and the socio-economic characteristics of the area from which the first admissions are taken and into which they presumably return, the other basis for the selection of the specific hospital is the type of area which the hospital serves.

Changes in the Status of First Admissions

In order to furnish as broad and as typical a basis as possible for the selection of the hospitals for analysis, a preliminary examination was made of the rates of movement for all state hospitals for all years from 1947 to 1953. The principal sources of movement from the hospital are discharge and convalescent status, and these were the indexes used for the comparison. Table 2 summarizes these data.

Table 2 indicates that Newberry State Hospital had an annual average rate of discharge and convalescent status which

was considerably higher than that of any other state mental hospital, and one which stands in marked contrast to that of Kalamazoo State Hospital. The two hospitals which were most similar in this respect were Pontiac State Hospital and

TABLE 1. DIAGNOSTIC GROUPS BY DIAGNOSTIC CATEGORY, NUMBER AND PERCENT IN DIAGNOSTIC GROUP, AND PERCENT RETAINED IN HOSPITAL 3.5 YEARS FOLLOWING FIRST ADMISSION

<i>Diagnostic Group</i>	<i>Diagnostic Categories</i>	<i>No. and Percent in Group</i>		<i>Percent Retained</i>
I	Mental deficiency with psychosis; psychosis with epidemic encephalitis	363	1.8	46.8
II	Convulsive disorder; personality disturbances due to epidemic encephalitis without psychosis; mental deficiency without psychosis; general paresis; paranoia and paranoid conditions; schizophrenic; other forms of syphilis of the central nervous system...	7,437	37.7	34.1
III	Organic changes in the central nervous system; traumatic psychosis; psychopathic personality with psychosis; psychosis with cerebral arteriosclerosis; senile; other, undiagnosed, and unknown psychosis; epilepsy without psychosis	6,942	35.1	22.2
IV	Primary behavior disorder without psychosis; involutional; psychosis due to metabolic, etc., diseases; alcoholic with psychosis; psychosis with other infectious disease; manic-depressive; other, unclassified, and unknown without psychosis; disturbances of circulation with psychosis.....	2,681	13.6	15.8
V	Drugs and poisons with psychosis; psychopathic without psychosis; psychosis due to new growth; psychoneurotic; alcoholic without psychosis; drug addiction without psychosis.....	2,329	11.8	5.5
Total		19,752	100.0	

Traverse City State Hospital. On the basis of these and other supporting data ³ it was decided to base this report on a comparison of Newberry with Kalamazoo and Pontiac with Traverse City. In the one case, an institution with a high discharge rate located in a predominantly rural area is compared with an institution with a low discharge rate located in a predominantly urban area. In the other case, two institu-

TABLE 2. AVERAGE RATE PER 1,000 RESIDENT POPULATION OF DISCHARGE AND CONVALESCENT STATUS BY HOSPITAL, 1947-1953

<i>Hospital *</i>	<i>Average Rate per 1,000 Resident Population of Discharge and Convalescent Status, 1947-1953</i>
Kalamazoo	72.8
Newberry	171.1
Pontiac	117.4
Traverse City	129.3
Ypsilanti	103.6
All hospitals	108.9

* Exclusive of Ionia and Wayne County (Eloise).

Source: *Public Health Service Reports* for 1947 through 1953 as compiled by the statistics and procedures section of the Michigan Department of Mental Health.

tions with similar rates of movement out of the hospital, but which differ in degree of urbanization of the service area, are compared.

A more specific analysis was made of data on first admissions to the four hospitals for the years 1945, 1948, and 1950. The first admissions were classed according to diagnostic group and status 3.5 years following admission. In the following analysis, these three groups of first admissions are combined.

It is clear, of course, that this report must be understood to refer only to the experience of one state during a specific period. The analysis ignores variation within this period.

Table 3 presents some of the basic data for this analysis. The table indicates the percentage of first admissions for all three

³ The supporting data consisted of an analysis of retention rates and of all rates of changes in status by broad diagnostic categories for three groups of first admissions for the hospitals. In addition, all hospitals were ranked in regard to these various measures both for the specific years and for the total period. In all cases, Newberry State Hospital exhibited a much higher rate of movement out of the hospital than did any other state hospital; and in five of the nine comparisons, Kalamazoo exhibited the lowest rates of movement.

years in the status group in which they are found 3.5 years following admission for the four hospitals concerned in this report.

Table 3 substantiates the evidence gained from an examination of all first admissions for the seven-year period. That is, Newberry has the highest rate of discharge and the lowest rate of retention, and Kalamazoo has the lowest rate of discharge and the highest percentage retained.⁴

TABLE 3. PERCENT OF ALL FIRST ADMISSIONS (1945, 1948, 1950) BY STATUS^a 3.5 YEARS FOLLOWING FIRST ADMISSION BY SELECTED HOSPITALS AND STATE TOTAL

<i>Hospital</i>	(1) <i>Resident and Family Care</i>	(2) <i>Convalescent Status</i>	(3) <i>Discharge</i>	(4) <i>Death</i>	(2)+(3)
All hospitals...	24.4	10.7	35.5	26.7	46.2
Newberry	18.5	10.6	42.8	24.4	53.4
Kalamazoo	26.8	21.8	21.3	29.0	43.1
Pontiac	25.7	10.9	36.1	27.3	47.0
Traverse City ..	23.9	12.6	37.0	26.5	49.6

^a Excludes transfers.

The percentage of first admissions dying within 3.5 years following admission is similar for all hospitals, but it should be noted that Newberry has the lowest percentage of deaths and Kalamazoo the highest. Table 3 indicates in general that differences in the percentage of first admissions who remain in the hospital are largely due to differences in discharge and convalescent status placements, and not to differences in percentage of patients who die.

The question arises, then, to what is this difference due? This report attempts to examine the proposition that differ-

⁴ This relationship holds when convalescent status and discharge percentages are combined. It is difficult to determine whether or not these two categories should be treated as essentially the same, i.e., reflecting movement out of the hospital by living patients, or as essentially different. It may well be that there are specific policies in each hospital which influence the placement of a patient on convalescent status rather than direct discharge and that the policy may have little to do with the psychiatric condition or prognosis of the patient. It is also possible that the two statuses indicate a different type of prognosis and patient. These are typical of the difficult and perplexing questions which make clear-cut answers to specific questions difficult to achieve. (For an analysis which deals with this topic, see: "A Statistical Inquiry with Respect to the Release and Discharge of Patients in Mental Hospitals," Statistics and Procedures Section, Michigan Department of Mental Health, July, 1953.)

TABLE 4. PERCENT OF ALL FIRST ADMISSIONS (1945, 1948, 1950) BY DIAGNOSTIC GROUP FOR ALL HOSPITALS AND FOR SELECTED HOSPITALS

Hospital	No. of First Admissions	Diagnostic Group ^a					Total
		I	II	III	IV	V	
All hospitals....	19,752	1.8	37.7	35.1	13.6	11.8	100.0
Newberry	955	2.8	24.3	35.6	19.7	17.6	100.0
Kalamazoo	1,424	1.0	38.0	40.2	9.8	11.0	100.0
Pontiac	1,397	1.6	39.4	32.0	15.7	11.3	100.0
Traverse City...	1,683	2.7	32.9	35.7	11.4	17.3	100.0

^a The diagnostic groups are arranged in descending order with respect to the proportion of first admissions retained 3.5 years following first admission. That is, diagnostic group I has the highest proportion retained, and diagnostic group V the lowest.

ences in discharge (and hence retention) rates are directly related to differences in the diagnostic composition of the groups of first admissions. The very important assumption that the diagnoses are the same, *i.e.*, the same psychiatric criteria are used with equal competence by all those who make the diagnosis, underlies this proposition.

In Table 4, a comparison is made between the four hospitals selected for this report in terms of the diagnostic composition of the first admissions to the hospital for 1945, 1948, and 1950. The time at which a change in status occurred is not determinable, and the analysis deals in effect with two points in time: first admission and status 3.5 years following first admission.

From Table 4 it can be seen that considerable variation occurs in the distribution of first admissions in those diagnostic groups categorized on the basis of similarity in change in status.⁵ For example, Kalamazoo has 79.2 per cent of all first

TABLE 5. PERCENTAGE OF FIRST ADMISSIONS DISCHARGED AND ON CONVALESCENT STATUS 3.5 YEARS FOLLOWING FIRST ADMISSION AND PERCENTAGE OF FIRST ADMISSIONS IN LOW-RISK DIAGNOSTIC GROUPS

Hospital	First Admissions Discharged and on Convalescent Status	First Admissions in Low-Risk Diagnostic Groups
Newberry	53.4	37.3
Kalamazoo	43.1	20.8
Pontiac	47.0	27.0
Traverse City	49.6	28.7

⁵ Goodness-of-fit tests indicate that none of the hospitals are representative of the total hospital population in terms of diagnostic groupings. Significant differences were also found between the diagnostic distributions of Traverse City and Pontiac and between those of Newberry and Kalamazoo.

admissions in the three diagnostic groups with the highest percentage of residence in the hospital after 3.5 years; Newberry has 62.7 percent in these three groups. Pontiac has 73.0 percent and Traverse City 71.3 percent of all first admissions in these three categories.

Table 5 offers tentative evidence of a direct relationship between the diagnostic composition of first admissions and the subsequent movement out of the hospital by means other than death. The table compares the percentage of first admissions discharged and on convalescent status with the percentage of first admissions in the two diagnostic groups with the lowest proportion of first admissions remaining in the hospital. These two groups are referred to as "low-risk" diagnostic groups.

A detailed examination of the relationship between diagnostic composition and change in status was also carried out.

A concise summary of these data is offered in Table 6, where the diagnostic groups are dichotomized and compared in terms of the status of first admissions 3.5 years following admission.

Table 6 permits a comparison of the percentage of all first admissions in a specific status classification 3.5 years following admission with the percentage of all first admissions in the two broad diagnostic groups, *i.e.*, the "low-risk" and "high-risk" groups. An example will serve to illustrate the interpretation of the table: The "high-risk" diagnostic group contains approximately 63 percent of all first admissions to Newberry, and this diagnostic group comprises approximately 90 percent of all first admissions resident in the hospital and in family care 3.5 years following first admission.

In Table 7, ratios are presented which permit a description of the extent to which a specific diagnostic group is under or over-represented in a specific status classification. For example, the high-risk diagnostic group is over-represented in the resident and family care status classification in all the hospitals, while the low-risk diagnostic group is under-represented in this status classification in all the hospitals. It should be clear that the low-risk diagnostic group contributes a much larger proportion of discharges and a much lower number of residents than the high-risk diagnostic groups.

TABLE 6. DIAGNOSTIC COMPOSITION OF STATUS CATEGORIES 3.5 YEARS FOLLOWING ADMISSION BY BROAD DIAGNOSTIC GROUPS FOR FIRST ADMISSIONS (1945, 1948, 1950) FOR SELECTED HOSPITALS, IN PERCENTS

<i>Hospital</i>	<i>Diagnostic Groups I, II, III</i>					<i>Diagnostic Groups IV, V</i>			
	First Admissions	Resident and Family Care	Conval. Status	Discharge	Death	First Admissions	Resident and Family Care	Conval. Status	Discharge, Death
Newberry	62.7	90.4	66.3	35.0	90.6	37.3	9.6	33.7	65.0 9.4
Kalamazoo	79.2	89.3	73.7	61.8	87.9	20.8	10.7	26.3	38.2 12.1
Pontiac	73.1	86.6	75.6	58.2	78.8	26.9	13.4	24.4	41.8 21.2
Traverse City..	71.3	87.8	68.9	46.8	91.5	28.7	12.2	31.1	53.2 8.5

TABLE 7. RATIO OF FIRST ADMISSIONS (1945, 1948, 1950) IN STATUS CATEGORIES 3.5 YEARS FOLLOWING FIRST ADMISSION TO FIRST ADMISSIONS IN BROAD DIAGNOSTIC GROUPS FOR SELECTED HOSPITALS

<i>Hospital</i>	<i>Diagnostic Groups I, II, III</i>				<i>Diagnostic Groups IV, V</i>			
	Resident and Family Care	Conval. Status	Discharge	Death	Resident and Family Care	Conval. Status	Discharge	Death
Newberry	1.441	1.057	.558	1.444	.257	.903	1.742	.252
Kalamazoo	1.127	.930	.780	1.109	.514	1.278	1.836	.581
Pontiac	1.184	1.034	.796	1.077	.498	.907	1.553	.781
Traverse City	1.231	.966	.656	1.283	.425	1.083	1.853	.296

This would seem to offer evidence that since a greater proportion of diagnostic groups IV and V are discharged, a hospital with a higher proportion of these patients would be characterized by a higher over-all discharge rate and a lower retention rate.

A final comparison of the relationship between the proportion of admissions in the low-risk diagnostic categories and discharge from the hospital is presented in Table 8.

This table clearly indicates that those hospitals which have a higher proportion of first admissions in the low-risk diagnostic groups also have a higher proportion of discharges than any other hospital. It is also clear that this is not a perfect relationship, but nonetheless the pattern is clear.

Table 9 presents a comparison of differences between hospitals in diagnostic composition and in percent of patients discharged and on convalescent status 3.5 years following first admission.

The additional consideration of convalescent status and discharge modifies the degree of differences between the hospitals but does not alter the pattern described in Table 8 and in the previous discussion.

The foregoing analysis has served to indicate that differences in proportion of first admissions discharged 3.5 years following admission between various hospitals are due, at least in part, to the diagnostic composition of the group of first admissions upon admission.

The data presented in this report confirm the hypothesis that inter-hospital differences in discharge and retention rates are positively associated with differences in the diagnostic composition of the groups of first admissions to the specific hospitals for the three selected years. The next analysis is concerned with the examination of some factors which may account for this differential diagnostic composition and the differential rates of movement from the hospital.

A full explanation of these differences would require complete data, for the periods considered, in regard to three general areas:

1. The structure of the specific institutions with information on the facilities available for the care and treatment of patients.

TABLE 8. DIFFERENCE BETWEEN SELECTED HOSPITALS IN PERCENT OF FIRST ADMISSIONS (1945, 1948, 1950) IN LOW-RISK DIAGNOSTIC GROUPS AND DIFFERENCE IN PERCENT OF FIRST ADMISSIONS DISCHARGED 3.5 YEARS FOLLOWING ADMISSION

Differences Between Hospitals in Percent of First Admissions Discharged Within 3.5 Years Following First Admission

Hospital	<i>Differences Between Hospitals in Percent of First Admissions in Low-Risk Diagnostic Groups</i>				<i>Differences Between Hospitals in Percent of First Admissions Discharged Within 3.5 Years Following First Admission</i>			
	Newberry	Kalamazoo	Pontiac	Traverse City	Newberry	Kalamazoo	Pontiac	Traverse City
Newberry .....	...	16.5	10.3	8.6	...	21.5	6.7	5.8
Kalamazoo	-16.5	...	-6.2	-7.9	-21.5	...	-14.8	-15.7
Pontiac	-10.3	6.2	...	-1.7	-6.7	14.8	...	-0.9
Traverse City	-8.6	7.9	1.7	...	-5.8	15.7	0.9	...

NOTE: This table is to be read across. For example: Newberry had 16.5 percent more first admissions diagnosed in the low-risk groups than did Kalamazoo, and 21.5 percent more first admissions discharged than did Kalamazoo. The lower half of each table contains entries which differ only in sign from the upper half entries.

TABLE 9. DIFFERENCES BETWEEN SELECTED HOSPITALS IN PERCENT OF FIRST ADMISSIONS (1945, 1948, 1950) IN LOW-RISK DIAGNOSTIC GROUPS AND DIFFERENCES IN PERCENT OF FIRST ADMISSIONS DISCHARGED AND PLACED ON CONVALESCENT STATUS WITHIN 3.5 YEARS FOLLOWING FIRST ADMISSION

Differences Between Hospitals in Percent of First Admissions Discharged and on Convalescent Status Within 3.5 Years Following First Admissions

Differences Between Hospitals in Percent of First Admissions in Low-Risk Diagnostic Groups

Hospital	<i>Differences Between Hospitals in Percent of First Admissions in Low-Risk Diagnostic Groups</i>				<i>Differences Between Hospitals in Percent of First Admissions Discharged and on Convalescent Status Within 3.5 Years Following First Admissions</i>			
	Newberry	Kalamazoo	Pontiac	Traverse City	Newberry	Kalamazoo	Pontiac	Traverse City
Newberry .....	...	16.5	10.3	8.6	...	10.3	6.4	3.8
Kalamazoo	-16.5	...	-6.2	-7.9	-10.3	...	-3.9	-6.5
Pontiac	-10.3	6.2	...	-1.7	-6.4	3.9	...	-2.6
Traverse City	-8.6	7.9	1.7	...	-3.8	6.5	2.6	...

2. The characteristics of the groups of first admissions which are related to movement. Thus, if a high discharge rate is associated with a large number of admissions who are less severely ill than admissions in another hospital, this characteristic of the group of admissions is of significance in influencing subsequent movement. The analysis already presented dealt only with diagnosis, and did not take into account other significant factors such as physical condition, age, and prognosis.
3. The characteristics of the area to which the admissions are returned upon discharge or convalescent status. That is, the type of environment in which a person must live is a factor which influences the likelihood of movement out of the hospital. The effect of the type of environment on admission is obviously another important factor in influencing possible later movement out of the hospital. This point is considered only insofar as diagnosis reflects differential incidence of mental illness, and emphasis here is placed on movement *from* the hospital.

Because complete data in regard to these three general areas are unavailable, the only examination which can be made of these factors is a broad exploratory one, and the findings must be viewed as tentative. The following comments are concerned with broad analysis of these factors.

Availability of Treatment Facilities

One factor which may be presumed to be associated with a high percentage of discharged first admissions is the treatment available to the first admissions.⁶ The indexes of available treatment facilities which are used in this report are the staff-patient ratio within the hospital, and the ratio of patients to each of the occupational groups. Table 10 summarizes this information for the selected hospitals.

Table 10 shows the ratio of staff members in each occupation to the resident population. For both physician and social worker Pontiac Hospital has the most "favorable" ratio of staff members to resident population and Kalamazoo has

⁶ It should be made quite clear that no evaluation of the quality of treatment can possibly be made, nor is any intended. The only reason for making this comparison is to "control" for differences between hospitals in the availability of facilities.

the least "favorable." Only in the case of the attendant does the hospital with the highest discharge rate enjoy the most favorable staff-patient ratio. This ratio is little different from the attendant-patient ratio for two other hospitals. It would seem, then, that variations in discharge rates between hospitals cannot be accounted for on the basis of differences in staff-patient ratios.⁷

"Selection" of First Admissions⁸

Here an attempt is made to determine what evidence is available to support the hypothesis that a selection of first ad-

TABLE 10. RATIO OF PATIENTS TO PROFESSIONAL STAFF BY OCCUPATION OF STAFF FOR SELECTED HOSPITALS

Occupation	Hospital			
	Newberry	Kalamazoo	Pontiac	Traverse
Physician	244	340	164	236
Social Worker	293	425	140	353
Nurse	105	92	155	74
Attendant	5.6	7.5	5.7	6.8
Total	5.08	6.71	5.23	5.96

missions takes place which influences discharge rate. The first step in this examination is an analysis of rates of incidence and prevalence of mental illness in the service areas of the various hospitals.⁹

⁷ These data on staff-patient ratios are not strictly related to the period covered in this study. However, there is no evidence that these ratios have changed since 1945 in any way which would seriously affect the conclusions. See "Total Employees in State Hospitals and Resident Population by Fiscal Year," Personnel Section, Michigan Department of Mental Health (no date). The average resident population for the period 1949-1952 was used as a base for the computation of the ratio.

⁸ "Selection" as used here and in the remainder of this report implies no conscious discrimination on the part of the hospital staff. The factors which may operate to select first admissions are "external" to the hospital system.

⁹ "Incidence" and "prevalence" are defined here solely in terms of first admissions and resident population respectively. Any inferences from these data to conclusions about "actual" or "real" incidence or prevalence must be made with extreme caution. See, for example, Kramer's discussion of this topic in which this point is strongly emphasized. [Morton Kramer, *A Discussion of Prevalence and Incidence*. Mimeographed. National Institute of Mental Health (no date).]

The assumption which underlies the present discussion is that any wide variation in incidence or prevalence is, in fact, not a function of actual incidence or prevalence, but a consequence of other factors, e.g., differential availability of facilities.

Table 11 presents information on rates of incidence and prevalence for the four hospital areas considered in this report. These data are limited in their applicability, since they do not cover the periods considered in the rest of the report, and they are based on only one year's experience.

The high rate of incidence and prevalence characteristic of Newberry are evidence that Newberry draws a greater pro-

TABLE 11. RATES (PER 100,000 GENERAL POPULATION FIFTEEN YEARS OF AGE AND OVER) OF FIRST ADMISSIONS (1948-1949) AND RESIDENT POPULATION (1953) FOR SELECTED HOSPITALS

<i>Hospital</i>	<i>First Admissions^a</i>	<i>Resident Population^c</i>
Newberry	145.5	597.3
Kalamazoo ^b	58.8	357.7
Pontiac ^a	47.8	258.0
Traverse City	91.7	370.3

^a Rates do not include Wayne County, which is not in the hospital service area. However, Wayne County does contribute admissions to these hospitals. If the Wayne County data are included, the rates become: First admissions: Kalamazoo—75.7; Pontiac—72.5. Resident population: Kalamazoo—124.6; Pontiac—106.7.

^b Data are for 1948-1949.

^c Data are for 1953.

portion of the population from its service area than does any other hospital. It was shown previously in this report that a smaller proportion of Newberry first admissions die in the hospital and that a greater proportion are discharged than in any other of the hospitals. This in addition to the fact that there are no other psychiatric facilities in the Newberry area¹⁰

¹⁰ There is abundant evidence that private psychiatric facilities admit a different group of first admissions than do state mental hospitals. For example, in 1950 and 1951 private psychiatric hospitals in Michigan had 8.8 percent of all first admissions in the category of cerebral, arteriosclerosis, and senile psychoses, while state hospitals had 26.9 percent of all first admissions in this category; private hospitals admitted 28.1 percent psychoneurotics, while state hospitals admitted only 7.3 percent. Patients admitted to state hospitals were older: 32.4 percent admitted to state hospitals were over 59, 15.4 percent of all admitted to private hospitals were over 59. That state mental hospitals have the great majority of long-term mental patients is indicated by the fact that in 1950 private mental hospitals accounted for 42.9 percent of all first admissions to both private and state hospitals, but had only 3.7 percent of the total resident population. (Source: *Patients in Mental Institutions, 1950 and 1951*. Public Health Service Bulletin No. 356).

This evidence suggests that state hospitals in areas where alternative psychiatric facilities are available have a high probability of admitting those patients with the more severe illnesses and the poorer prognoses.

The foregoing evidence also emphasizes the limitations of any attempt to draw conclusions as to "actual" incidence of mental illness which ignores admissions to private psychiatric facilities.

is tentative evidence that the admissions to Newberry are less severely ill than those to other state hospitals.

Additional evidence that Newberry State Hospital admits patients under different conditions than do the other hospitals is the fact that for none of the three years considered did Newberry have a waiting list, while the average waiting list for Kalamazoo was thirty-five potential admissions. This may be interpreted as a type of "pressure to admit."

Additional information in regard to this pressure to admit is offered in Table 12 in which the number of available beds per 100,000 general population is shown for each hospital.

TABLE 12. NUMBER OF BEDS SET UP PER 100,000 GENERAL POPULATION FIFTEEN AND OVER, 1940 AND 1950, FOR SELECTED HOSPITALS

<i>Hospital</i>	<i>Beds per 100,000 Population 15 and Over</i>	
	1940	1950
Newberry	583.2	699.7
Kalamazoo	400.4	406.4
Pontiac	448.8	357.2
Traverse City	411.4	448.0

These data have some important implications. For example, take two areas in which the incidence of mental illness is the same. In one is a hospital which must take a smaller proportion of admissions due solely to lack of facilities. The probability is that the patients admitted will be those with the more severe illnesses and hence less likelihood of movement out of the hospital. On the other hand, a hospital with a larger ratio of beds per 100,000 persons will be likely to admit both the more severe and less severe cases—again due solely to availability of beds.

From Table 12 it can be seen that solely on the basis of available facilities Newberry is able to admit a greater proportion of the potential hospital population in its service area than any other hospital. The evidence presented in the preceding pages suggests also that this proportion admitted is characterized by a shorter stay in the hospital, a higher discharge rate and a lower death rate.

None of the factors previously discussed, taken alone, would be strong evidence for any differential admission to the hospital. However, the combination of various kinds of evi-

dence, including different hospital experience, similarity in therapeutic facilities as indicated by staff-patients ratios, higher rates of first admission and resident population, a higher population-bed ratio, the absence of a waiting list, all serve to point in the same direction and to substantiate the proposition that the patients admitted to Newberry State Hospital are different and that this difference may account, at least in part, for the different experience of these groups of first admissions.

Social and Economic Characteristics of the Hospital Service Area

The selection of the four hospitals for comparison in this report was based in part on the relative proportion of the population of the hospital service area classed as urban. This is, of course a relatively crude basis of distinction,¹¹ which serves only to suggest differences in the characteristics of the various areas which may influence the probability of discharge for first admissions. Implicit in this distinction between urban and rural is the assumption that it is "easier" to "adjust" to a rural environment than to an urban environment.¹²

In order to assess more precisely the characteristics of the geographic area which may be presumed to be relevant to the likelihood that a first admission will be discharged, several additional factors are examined. The functional basis of the area, as indicated by the industrial composition of the labor

¹¹ The definition of urban used in this report is that in U. S. Bureau of the Census, *U. S. Census of Population: 1950*. Vol. II, *Characteristics of the Population*, Part 22, Michigan, Government Printing Office, Washington, D. C., 1952, pp. IV-V.

This definition differs from that used in previous censuses, and has had the effect of increasing the proportion of population classed as urban.

¹² It is also often assumed that the characteristics of urban life are more likely to produce mental illness than those of rural life. It is clear that on the face of the data which are available this assumption is untenable. However, the fact that rural rates of incidence are much higher than urban rates must be interpreted in the light of the limitations described above. The point is, however, that there would seem to be no evidence for assuming any advantage in rural life—on the basis of available information—from the viewpoint of probability of the occurrence of mental illness.

TABLE 13. URBAN-RURAL RESIDENCE, DENSITY, AND LABOR FORCE CHARACTERISTICS OF SELECTED HOSPITAL SERVICE AREAS, 1950
Percent of total empl'd persons by selected major industry groups

Hospital	Percent urban	Pop. per sq. mi.	Pop. chg. 1940-1950	Agriculture	Manu'g.	Wh. and ret. trade	Service ^a	Other ^b
Kalamazoo	60.1	145	17.9	9.6	36.7	18.1	14.3	21.3
Newberry	49.2	18	-6.6	11.3	22.6	17.5	14.3	34.3 ^c
Pontiac ^d	61.3	162	77.3	8.2	44.4	16.3	11.0	20.1
Traverse	38.2	43	8.8	17.3	30.7	17.2	12.6	22.2

^a Includes business and personal services (except private household) and professional and related services.

^b Includes mining, construction, transportation and communication, and finance, insurance and real estate.

^c In the Newberry service area, 10.8 percent of the labor force is employed in mining. This area contains 65.1 percent of all persons in the state employed in mining.

^d Excludes Wayne County.

Source: U. S. Bureau of the Census. *County and City Data Book, 1952.* (A Statistical Abstract Supplement) Government Printing Office, Washington 25, D. C., 1953. Table 3.

force, and the density of population in the area are the major factors considered.

Table 13 is a summary of these characteristics for the geographic areas served by the four state hospitals.

The comparison of the four hospital service areas offered in Table 13 permits an analysis of the factors which characterize an area and which may be related to the possibility of discharge. For instance, the Newberry service area is one of the least densely populated in the state,¹³ with the lowest proportion of the employed labor force in manufacturing and the highest proportion in mining. It is also the only one of the four service areas which lost population from 1940 to 1950. The Traverse City service area is the most agricultural, second only to Newberry in terms of low density of population, and it increased in population much less than the rest of the state from 1940 to 1950 (8.8 percent for Traverse City area and 21.2 percent for the entire state).

The general relationship, then, would seem to be that density of population and a manufacturing-based economy militate against a high probability of discharge. It should be made clear that these are, at best, still crude indexes to other social and environmental conditions which presumably influence human behavior. One implication of this type of analysis is that discharge is not only a consequence of psychiatric condition, but also of the general social conditions of the area into which the first admission is discharged. There is some evidence, then, that not only do Newberry and Traverse City admit patients with a higher probability of a short stay in the hospital, but that patients may be discharged to a non-industrialized, sparsely settled area who could not be discharged to a highly industrialized, densely settled urban area.¹⁴

¹³ There is a negative relationship between density of population and incidence of mental illness. The rank-order correlation between incidence and density for the 77 counties considered in the report was $-.313$. The r ho for each of the service areas was Newberry, $-.530$; Traverse, $-.066$; Kalamazoo, $-.250$; and Pontiac, $-.441$. This would seem to be additional evidence as to the importance of considering the availability of facilities in relationship to population when discussing incidence of mental illness.

¹⁴ Throughout this report it has been assumed that patients discharged from the hospital are discharged into one of the counties of the hospital service area. In any future research, this assumption would have to be verified.

Summary

1. The study confirmed the hypothesis that differences between hospitals in the proportion of first admissions discharged 3.5 years following first admission are associated with differences in the diagnostic composition of the first admissions.
2. These differences in proportion of first admissions discharged were shown not to be associated with differences in the facilities available for psychiatric treatment.
3. These differences could not be accounted for by differences in death rates in the four hospitals.
4. Variation in either administrative policy or characteristics of patients was indicated by wide differences in proportion of first admissions on convalescent status.
5. Evidence was presented that "selection" of patients as first admissions takes place in the four hospitals, with the selection favoring the hospital with the high proportion of discharged first admissions.
6. Evidence was also presented to indicate that the social characteristics of the hospital service area influenced the proportion of first admissions discharged. That is, low density of population and an economy other than manufacturing were positively associated with a high percentage of discharged first admissions.

A HOME CARE PROGRAM IN THE COMMUNITY¹

NELLIE W. HOLLIER AND ROBERT M. HARRISON²

Planning the Program

A HOME care program was initiated at the Veterans Administration Hospital in Palo Alto, Calif., on October 30, 1950. A week later the home care social worker and the chief of social service were conferring regarding means of finding homes when there was a knock at the office door. There stood before us Mrs. R, who was later to become our first sponsor. She told us that for two weeks Mr. M, a trial-visit patient, had been living in her home after being deposited there by a taxi-driver friend. Mrs. R had just learned of our home care program from a neighbor who was a psychiatric aide at the hospital. Her appeal was, "Can't you send me five other veterans just like Mr. M?"

Having our first sponsor "laid in our laps," as it were, was an example of how community interest in this program can take hold and gain momentum.

We devoted the first two months to reviewing the literature on other home care programs and Veterans Administration and state regulations on the subject, and to interpreting the program to the hospital staff and to the community. The chief of social service and the home care social worker addressed many community groups, such as veterans' organizations, churches, grange chapters, and the Veterans Administration voluntary services committee. We also conferred with representatives of numerous health and welfare agencies in the area. These activities plus subsequent newspaper publicity soon resulted in applications from a number of persons interested in becoming sponsors.

Cooperative relationships were developed with the local

¹ From the Veterans Administration Hospital, Palo Alto, Calif. (capacity: 1402 beds). The authors wish to express appreciation to the manager and the staff of the hospital for help in the preparation of this paper and to Raymond W. Craig, former chief social worker, for special contributions to the home care program of the hospital.

² Home care social worker and case supervisor of social service, respectively, at the VA Hospital, Palo Alto, Calif.

public welfare departments in order to share information on possible homes. Arrangements were made with the State Department of Mental Hygiene for the licensing of homes by that agency in accordance with state law. This department has concerned itself with such physical aspects of the homes as sanitation, fire hazards, and zoning. The selection, education, and supervision of sponsors as well as placement of veterans in the homes remain the responsibility of Veterans Administration Hospital personnel.

By the end of the first year, 1951, we had ten sponsors with whom we had placed our first fifty patients. To date (March 1955), four years later, we have used sixty-five different homes and have placed a total of 209 veterans. In June 1954 a second home care social worker was assigned to the project, as the placement and supervisory load had become excessive for one worker.

Success in our home care program has been facilitated by thorough orientation of the hospital staff in the philosophy and procedures of the program and by the help and guidance of hospital management. Personal interest on the part of management has sometimes been very meaningful to patients. For instance, a frightened, status-conscious, Chinese-born veteran was helped through the traumatic experience of leaving the hospital when the assistant manager rode with us out to the front gate. After three years, this veteran is discharged, but still living in the same sponsor's home. He has never forgotten that the assistant manager of this hospital is his friend and is interested in his welfare and progress.

Selection and Placement of Patients

The home care program is one part, a specialized part, of the total trial-visit program. Patients are selected and prepared for home care by the responsible ward psychiatrist and social worker, and from the point of referral for home care the efforts of the home care social worker are closely coordinated with those of the ward team. Factors considered in the selection of a patient include his dependency needs, his ability to assume partial responsibility for caring for himself, non-combativeness, ability to communicate, possibility of social and vocational rehabilitation, potentialities for change, sta-

bility of mood, personal habits, medical status, and sufficient funds. The usual amount paid a sponsor for board and room, laundry, and supervision has been \$125 a month. This has meant that patients have needed to have 100% service-connected compensation to be included in the program. The financial agreement is essentially one between the patient and his sponsor, although it is arranged and approved by the hospital. Besides these licensed homes, a number of part-work placements were located, particularly for non-service connected veterans who would otherwise have been financially unable to move into home care.

In each situation, an effort is made to obtain the understanding and cooperation of close relatives in support of the home care plan. Important considerations in the placement of the veteran are the matching of the patients to the sponsors and the matching of patients to one another. In some instances, the patient may be the only veteran in the home, but usually from two to six patients are placed in the same home. As a rule, there are both female and male parent figures in the home, but in some instances widowed or divorced women are sponsors. The ward team and home care social worker give careful thought to which patients may go into these homes and which ones also need the influence of a father figure.

Other factors in placement include the patient's preference for city or rural living, availability of employment, or nearness to the hospital if the psychiatric plan is for the patient to return for individual or group therapy or hospital activities during the day.

All patients referred by the ward psychiatrist and social workers receive invitations to attend the home care group led by a clinical psychologist and the home care social workers. Questions regarding home care are carefully answered and patients are free to express any concerns, anxieties, or other feelings they may have regarding home care. Patients already placed in home care often return to the group and their enthusiastic reports frequently give doubtful and insecure patients considerable reassurance.

As soon as a patient is attending the home care discussion group regularly and showing interest in trips outside the hospital, the home care social worker arranges a "look-see"

trip to visit at least three homes in the community. Sponsors are told ahead of time that a new patient is to visit their homes and they are briefed about the patient's problems and his needs.

Frequently veterans are frightened and insecure on their first trip out of the hospital. We have come to rely upon our sponsors to be warm and accepting but not to bring pressures to bear at the time of the first visit. For new sponsors, this experience is often a happier one than expected. They have made such remarks as "We like him very much and can't understand why he has been in a mental hospital all these years" or "He is very shy but we think we can help him and we would like to try." Many patients are sure that the first home is the right one but are encouraged to "sleep on it," or a week-end visit may be arranged before a decision is reached.

This period of experimentation can be very positive for both veteran and sponsor, giving each a chance to look over the field, to express his choice, his likes and dislikes, his fears, negative feelings, or uncertainty. Recently a veteran was "on the fence," as it were, for more than two years about a placement, but most patients are satisfactorily placed within a few weeks or months from the date of referral.

During the four years of the program, about one-third of the total number placed in home care have been moved to a second or a third home and, in a very few instances, to a fourth. The ability to express a desire to change homes on the part of both the patient and the sponsor is not entirely negative. One veteran, Mr. A, has moved at his request about once a year for three years now. In the first home he was practically spoon-fed and carried on in an infantile manner. In the second home he assumed a very different rôle. He began to eat well, gain weight, and bought a bicycle. Finally we moved him to a third home, this time in the city. In discussing this move he wondered if he would make as much progress in the third home as he had in the second. He is now a thorough-going city fellow and the ward psychiatrist is considering discharge for him with his guardian-brother.

Selection of Sponsors

Prospective sponsors come to our attention through many and varied sources. We first mail an application blank and

a descriptive folder which interprets the program and is good publicity. Each applicant is told that a home visit to interview the family will not be made by the home care social worker until a home in that area is needed. Factors considered in the selection of sponsors include emotional maturity, stable and congenial family relationships, soundness of motivation, financial security, and ability and willingness to utilize supervision. The home must meet minimum standards for space, fire safety, hygiene, and comfort. The home must appeal to the veteran and to some extent meet his individual needs and desires.

It is paramount that the sponsor have financial resources other than the fees paid by the veterans. If we are not ready to place a veteran in a sponsor's home at once the alternatives of renting the rooms privately or securing another type of license are frequently suggested. We have lost some good prospective sponsors because we could not make an early placement, but usually the applicant who sincerely desires to take veterans into her home will await the opportunity, sometimes for several months or even a year. Of the seventy sponsors participating in the program during the four-year period, twenty-five have dropped out, usually for health or financial reasons.

We have been fortunate in averaging five applications for home care sponsorship to one that has been accepted. This five-to-one ratio gives us the opportunity to pick and choose the sponsors we want and need. If an application is dropped, it is usually for one of the following reasons:

- (1) The applicant withdraws when she considers specific problems concerning mentally ill persons.

- (2) The applicant may already have a license for persons other than veterans in her home, and for more people than we allow in one home (six is our maximum).

- (3) The home may not meet the physical or financial standards for licensing.

- (4) The attitude of the applicant or members of the family may not be desirable.

- (5) The home may be located too far from the hospital (more than twenty-five or thirty miles).

Upon reviewing the forty sponsors' homes in which we are

now supervising veterans, we find many specialized situations like the following: A Russian home where two Russian-born veterans live; two Negro homes with one Negro veteran in one and two in the other; a home where rather close supervision is supplied to veterans who have had leukotomy operations; a town home where three of the four veterans are quite musical and where meals are followed by intellectual and philosophical discussions. In one of our homes two Chinese veterans and one Filipino veteran live. We have three Italian-born sponsors; two of these have veterans who like all-Italian food, Italian talk and culture, while the third is somewhat more Americanized.

In one small-town home, the sponsor's attitude is quite nurturing and mothering. One tract home was selected because of the physical convenience of the floor level for the crippled veteran's wheel chair. One home in a large city is more like a rooming house where two of the four veterans have regular full-time jobs. In one large city home, we placed veterans with alcoholic problems.

From the beginning, individual casework with the sponsor has been supplemented by group meetings of sponsors at the hospital. In these bi-monthly meetings various administrative and procedural matters are considered and the sponsors bring out problems that they encounter and interchange information regarding their approach to situations. The staff psychiatrists have been very active in the sponsors' meetings and have led discussions on such topics as:

- (1) Home care, a means of interpreting mental illness to the community.
- (2) The meaning of food to the patient.
- (3) Handling personality difficulties.
- (4) Problems of handling money.
- (5) The rôle of the patient in the home of the sponsor.

Public Relations

Our first negative experience in public relations occurred near the close of the first year of home care. A sponsor who had done a marvelous job with two of our post-leukotomy veterans wished to change her license from two to four patients. The application was filed correctly with the State

Department of Mental Hygiene, which routinely notified the city fire marshal to investigate this home. The fire marshal, instead of going directly to the home to inspect it, referred the matter to the city planning commission in a prejudicial manner. We learned of this through a newspaper headline—"Foster Home for VA Mental Patients Draws a Loud Protest." Some poorly informed but influential individuals and groups had been aroused and were demanding zoning restrictions which would prevent the licensing of homes in the vicinity. For weeks, the manager, the chief social worker, and the home care social worker were involved in delicate interpretive work with P.T.A. groups, the city planning commission, veterans' organizations, and civic leaders. As a result, the planning commission allowed our fine sponsor to continue with her two veterans, but has never approved four veterans in her home.

This experience emphasized the need for interpretation of the program. We stimulated a series of feature articles in the local press. We learned to keep in touch with the district attorney. We requested that one of his deputies be assigned to us for trouble-shooting. Once when a sponsor's dog got into a fight with a neighbor's dog, there was a bitter quarrel, with the neighbor complaining to the district attorney's office, not about the dog but about the veterans in the sponsor's home. The deputy district attorney uncovered the real source of the difficulty and settled the problem. The four veterans are still in that home and the sponsor and her neighbor are good friends.

We have learned that no sponsor's license is stronger than her most prejudiced and hysterical neighbor! If we learn of trouble and whispering about the veterans, our approach is to call with the sponsor on neighbors for several blocks around. There we listen carefully to their complaints and do everything possible to interpret and explain our program. Usually this allays fears and prejudice and avoids publicity or involvement with planning commissions, police, and other authorities.

A sponsor from our one large city, who cares mainly for patients with drinking problems, has had to limit the men's drinking habits quite firmly. Occasionally one of these veterans lands in jail for excessive drinking. The sponsor and the hospital have an excellent working relationship with the

police authorities in handling these situations. Most of the veterans in this home have made progress in the handling of their drinking problems.

Supervision of Homes

Communication remains important throughout the entire home care period. In some cases the responsible doctor has regular interviews with the patient. In all cases the home care worker keeps the ward psychiatrist and the ward social worker informed regarding the adjustment of the patient in the home. If the initial placement is not successful, the home care social worker and the responsible doctor decide whether the patient should be returned to the hospital or transferred to another home.

The relationship between the home care worker and the sponsor is of utmost importance. As problems arise sponsors frequently call the home care worker, and the worker, of course, makes regular visits to the homes. Visits are usually once a week for the first month of placement and less frequent thereafter. Many of the veterans request personal interviews during the visits to the home, but primarily the home care worker provides service to the veteran through help to the sponsor. It is the sponsor who lives with him twenty-four hours a day and it is to her that he looks for guidance and help with his daily problems.

The sponsor understands that she and her home are considered an extension of the hospital. She is entrusted with background information and other necessary data regarding the veteran's treatment and progress. The sponsor feels free to ask questions and depends upon the home care social worker for advice and suggestions.

Evaluation

Evaluation of the 209 patients who have been placed in home care reveals that only 45 are now back in the hospital. It is estimated that about 20, or nearly half, of these 45 will be able to return to home care or other trial-visit soon. Six of the 209 are now deceased.

Success in home care is not easily measured. We have judged success not only by the number of veterans who have moved out

of the hospital into home care or by the number who have moved from home care to straight trial-visit or discharge and more independence, but also by the number of veterans (26 at the moment) who have remained in our sponsors' homes following discharge. Many patients have demonstrated to their families that they can live successfully outside the hospital and have been accepted again in their own homes. Others who have no families or whose families remain unaccepting have found permanent homes and a permanent welcome with their sponsors.

Discharge planning participated in by patient, ward doctor, and sponsor is our final casework service. Discharge is the culmination of our rehabilitative program, the goal of which is to help the veteran become a part of his community, independent, productive, and well-adjusted.

Home care is primarily a part of the treatment program. Secondly, however, it is a program of mental health education. The home care sponsors are in the forefront in this interpretive effort. The understanding and acceptance of mental illness and the knowledge of the hospital they have acquired through participation in the home care program are passed on to relatives, friends, neighbors, and organizations in the community.

COHORT STUDIES OF MENTAL DISEASE IN NEW YORK STATE, 1943 TO 1949 *

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PART II. GENERAL PARESIS

THERE has been a remarkable and steady decrease in the rate of first admissions with general paresis to the New York civil state hospitals since the third decade of the century. Despite an increase of 40 percent in the population of New York state since 1920, the number of first admissions with general paresis has decreased by almost 75 percent. The rate of first admissions per 100,000 population fell from approximately 8 to less than 2.

However, the decrease in first admissions with general paresis has not brought about a decrease in their number on the books of these hospitals. In 1920, for example, there were 1,365 general paretics on the books, representing 3.6 percent of the total. In 1950, however, they totaled 3,686, or 3.9 percent of the total. This incongruous and unexpected trend would seem to be incompatible with the results of modern therapies. Yet, in fact, it is a direct consequence of the improvements in therapy. The usual types of hospital statistics cannot explain adequately this apparent inconsistency. To determine what happens to hospitalized first admissions with general paresis it is necessary to follow systematically the histories of a cohort of such admissions.

The following analysis is based upon five cohorts of first admissions with general paresis to the New York civil state hospitals. The first cohort was admitted during the fiscal year ended March 31, 1944. Similar cohorts were obtained from the admissions of each of the succeeding four fiscal years. As shown in Table 1, the five cohorts totaled 2,923.

* This is the second of a series of eight or nine reports based on an investigation supported by a research grant from the National Institute of Mental Health, of the National Institutes of Health, United States Public Health Service.

TABLE 1. FIRST ADMISSIONS WITH GENERAL PARESIS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943-1944 TO 1947-1948 INCLUSIVE

<i>Fiscal year</i>	<i>Males</i>	<i>Females</i>	<i>Total</i>
1943-1944.....	480	187	667
1944-1945.....	468	188	656
1945-1946.....	433	134	567
1946-1947.....	399	142	541
1947-1948.....	360	132	492
Total	2,140	783	2,923

The first admissions decreased during the period of five years from 667 during the year ended March 31, 1944 to 492 during the year ended March 31, 1948. This is in accordance with the decreasing trend of such admissions, which began during the decade 1920-1929.

The age distribution of the 2,923 first admissions is summarized in Table 2. They were included largely within the age limits of 35 to 59 years. This interval included 2,098 first admissions, or 71.8 percent of the total. Of the remainder, 342, or 11.7 percent, were under 35 years of age, and 477, or 16.3 percent, were aged 60 or over. The heaviest concentration was from 40 to 49 years. For both males and females, the admissions were grouped predominantly in the middle age periods, but the concentration was more marked for males,

TABLE 2. FIRST ADMISSIONS WITH GENERAL PARESIS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943-1944 TO 1947-1948 INCLUSIVE, CLASSIFIED ACCORDING TO AGE

<i>Age (years)</i>	<i>Number</i>			<i>Percent</i>		
	<i>Males</i>	<i>Females</i>	<i>Total</i>	<i>Males</i>	<i>Females</i>	<i>Total</i>
Under 25	31	27	58	1.4	3.4	2.0
25-29	32	40	72	1.5	5.1	2.4
30-34	133	79	212	6.2	10.1	7.3
35-39	283	100	383	13.2	12.8	13.1
40-44	391	123	514	18.3	15.7	17.6
45-49	383	122	505	17.9	15.6	17.3
50-54	294	100	394	13.7	12.8	13.4
55-59	280	72	352	10.7	9.2	10.3
60-64	181	61	242	8.5	7.8	8.3
65-69	101	34	135	4.7	4.3	4.6
70 or over.....	77	23	100	3.6	2.9	3.4
Unascertained ...	4	2	6	0.2	0.3	0.2
Total	2,140	783	2,923	100.0	100.0	100.0

who included 73.8 percent within the interval of 35 to 59 years, as compared with 66.1 percent of the females.

The statistics of discharge are summarized in Table 3, which includes the percentages discharged within successive periods after admission. Since the annual cohorts were followed for unequal years of exposure, varying from a minimum of one year to a maximum of five years, the percentages of discharge

TABLE 3. FIRST ADMISSIONS WITH GENERAL PARESIS TO THE NEW YORK CIVIL STATE HOSPITALS DISCHARGED DURING SPECIFIED PERIODS AFTER ADMISSION, CLASSIFIED ACCORDING TO PERCENTAGE AND RATE

<i>Period of Hospitalization</i>	<i>Males</i>			<i>Females</i>		
	<i>Per- cent</i>	<i>Cumula- tive Per- cent</i>	<i>Rate per 1,000 Exposures*</i>	<i>Per- cent</i>	<i>Cumula- tive Per- cent</i>	<i>Rate per 1,000 Exposures*</i>
First three months..	2.7	2.7	130.5	2.6	2.6	118.3
Second three months.	1.5	4.2	81.4	2.0	4.6	104.7
Third three months.	0.6	4.8	37.2	0.3	4.9	21.0
Fourth three months	0.5	5.3	33.4	0.8	5.7	44.1
First year.....	5.3	5.3	63.7	5.7	5.7	66.0
Second year	19.9	25.2	352.6	25.8	31.5	388.9
Third year.....	3.4	28.6	111.9	4.1	35.6	115.4
Fourth year.....	1.8	30.4	78.2	1.1	36.7	41.7
Fifth year.....	0.8	31.2	45.4	0.5	37.2	21.1

* On an annual basis.

for each period after hospitalization are averages based upon the corresponding base totals. Thus, since each cohort was exposed for at least one year to the chance of discharge, the percentage so discharged was based upon the total admissions of the five cohorts. The cohort for 1947-1948 was followed for only one year; hence, the exposure for the second year after admission could be derived only from the experience of the remaining four cohorts. Finally, only the cohort of 1943-1944 was followed for five years; hence, the percent and rate of discharge during this period were derived from the experience of this cohort alone.

Of the male first admissions with general paresis, an average of 31.2 percent were discharged within five years after admission, compared with 42 percent of all male first admissions. Discharges were few during the first year, representing only 5.3 percent of the total first admissions with general paresis. Almost half of the discharges within this period occurred dur-

ing the first three months. Discharges dropped to only 0.5 percent of the first admissions during the final quarter of the first year after admission. They rose to 19.9 percent during the second year of hospitalization. Relatively few general paretics are placed in convalescent care. Therefore, it may be concluded that the percentage of discharges during the second year represents primarily direct discharges from the hospital, and that such discharges are few during the first year and also after the second year of hospitalization. It is also evident that the chance of discharge decreases very rapidly after the second year.

Of the female first admissions with general paresis, 37.2 percent were discharged within five years, compared with 43.5 percent for all female first admissions. The percentage of discharge for female general paretics was higher than the corresponding percentage for males. This resulted from the relatively greater number of discharges among females during the second year after hospitalization. Thus, 25.8 percent of the females were discharged during this period, compared with 19.9 percent of the males. Discharges were few during the first year, and still fewer after the second year.

If these percentages of discharge appear, in general, to be low, they are nevertheless in marked excess over corresponding statistics for an earlier period. Thus, a study¹ of a cohort of male first admissions with general paresis to the New York civil state hospitals in 1909-1910 showed that only 13.5 percent were discharged within five years after admission, which may be compared with 31.2 percent of current admissions. Furthermore, 8.5 percent were discharged during the first year among the earlier admissions, compared with only 5.3 percent of the current group, but the earlier discharges amounted to only 2.5 percent during the second year, compared with 19.9 percent so discharged between 1943 and 1949. The difference may be attributed to the absence of a specific type of therapy for general paresis during the earlier epoch, and the application of specific forms of chemotherapy in this generation. Patients are retained in the hospitals during the course of the therapies, and subsequently become eligible for discharge. Thus, we now have, as a result of these therapies, higher rates of discharge, but they occur at a later period after admission.

The statistics for female first admissions with general paresis show similar results. As with contemporary cohorts of general paretics, females had higher percentages of discharge than males four decades ago.² However, only 20.5 percent of the females were discharged within five years after hospitalization, compared with the current percentage of 37.2. The discharges during the earlier period rose from 13.3 percent of the total admissions during the first year to a cumulative total of only 17.5 percent during the second year. The discharges among the current female cohorts amounted to only 5.7 percent during the first year after admission, but rose to 31.5 percent by the end of the second year.

The exact probability of discharge can be obtained only by relating the discharges to the corresponding population at risk. The chance of discharge during the first year depends upon the number exposed to the possibility of discharge during that period. The chance of discharge during the fifth year depends upon the number of the original cohort remaining until this period and therefore subject to the chance of discharge during the fifth year. Table 3 summarizes the probabilities of discharge during specified periods after admission.

Among males, the rate of discharge was 130.5 per 1,000 annual exposures during the first three months after admission. The rate of discharge decreased during the remainder of the first year to 33.4 during the final quarter of the year. The average rate for the first year was 63.7. The rate increased almost six-fold to 352.6 during the second year after admission, but fell rapidly thereafter to 45.4 during the fifth year.

Females showed a similar trend. The rate of discharge began with 118.3 per 1,000 annual exposures during the first three months after admission and decreased to 44.1 during the final quarter of the year. The average for the first year was 66.0. The rate rose to 388.9 during the second year, then decreased steadily to 21.1 during the fifth year. Females had higher rates of discharge than males during the first years after admission, but lower rates during the subsequent years.

As with percentages of discharge, the rate of discharge was higher during the first year of hospitalization for the early cohort³ than for the current cohorts. Thus for males, the

rates were 108.1 and 63.7 for the respective cohorts. During the second year, however, the rates were 63.6 and 352.6 respectively. The rate of discharge within two years after admission increased among males from 159.0 to 317.3. Similarly among females, the rate of discharge during the first year was higher for the earlier cohort. This was reversed during the second year, the rate for the current female cohorts being 388.9 as compared with 91.9 for the early cohort. The rate of discharge within two years after admission was 229.5 for the early female cohort, compared with 371.8 for the recent female cohorts.

Table 4 shows the rates of discharge during specified periods after admission, correlated with age at first admission. It was shown previously that the rates of discharge rose to a maximum during the second year of hospitalization and decreased subsequently. This trend repeats itself, with minor fluctuations, in all age groups. In each period of hospitalization, however, the rates decreased with advancing age at first admission.

Among males, the discharge rates fell during the first year of hospitalization from 80 or over at ages under 45 to 50 or less at the older ages. There was a more definite trend during the second year of hospitalization. The rates of discharge were at a maximum below age 40 and declined to minima at ages 60 or over.

Among females, the discharge rates fluctuated somewhat erratically due to small numbers, but during the second year of hospitalization they too followed the trend of inverse relation with respect to age at first admission.

Table 5 summarizes the condition of the patients at time of discharge. It has been shown that the bulk of discharges occurred during the first two years of hospitalization. All the cohorts, except that of 1947-1948, provided data for this period. These cohorts included 2,431 first admissions with general paresis. Of this total, 5.6 percent were recovered, 13.9 percent were much improved, 5.8 percent were improved, and 1.7 percent were unimproved. Females showed somewhat higher rates of recovery and improvement than males.

These percentages contrast favorably with the experience of the cohort of 1909-1910.⁴ In the latter years, no patients were discharged as recovered within two years after admis-

TABLE 4. RATES OF DISCHARGE * AMONG FIRST ADMISSIONS WITH GENERAL PARALYSIS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS OF ADMISSION, CLASSIFIED ACCORDING TO AGE AT FIRST ADMISSION

Age at First Admission (Years)	Males										Females									
	1st three mos.†	2nd three mos.†	3rd three mos.†	4th three mos.†	1st year	2nd year	3rd year	4th year	5th year	(1000.0)	1st three mos.†	2nd three mos.†	3rd three mos.†	4th three mos.†	1st year	2nd year	3rd year	4th year	5th year	(1000.0)
Under 25	182.8	.....	.....	.....	35.1	378.4	222.2	.....	(1000.0)		316.8	180.8	.....	.....	120.0	315.8	166.7	.....	.....
25-35	.....	142.2	306.3	.....	101.7	512.8	111.1	.....	250.0		102.2	107.8	.....	.....	53.3	491.2	190.4	222.2	.....
35-45	129.7	69.9	86.3	74.6	72.9	397.7	112.7	166.7	250.0		104.8	113.4	.....	124.8	81.6	509.8	50.0	100.0	166.7	
45-55	224.2	112.4	60.3	41.4	100.2	466.6	132.1	100.0	.....		130.3	93.7	48.7	.....	64.5	393.7	114.3	.....	.....
55-65	218.8	171.6	28.6	14.8	84.3	386.0	79.1	17.7	58.8		148.0	159.6	.....	.....	71.7	462.8	107.1	50.0	.....
65-75	88.7	86.6	46.6	16.4	56.1	357.3	122.7	95.2	.....		75.9	167.1	.....	46.9	65.7	294.1	88.2	.....	.....
75 or over	68.4	.....	21.6	45.2	29.4	301.1	113.8	32.8	.....		136.8	.....	.....	.....	34.4	472.7	171.4	.....	.....
.....	197.0	55.8	.....	37.4	72.7	352.1	169.4	.....	.....		77.1	88.2	90.9	.....	52.6	800.0	.....	100.0	.....
.....	111.6	34.3	39.0	44.7	50.9	177.0	35.7	90.9	.....		83.6	.....	109.6	261.3	86.0	196.1	74.1	.....	.....
.....	55.4	.....	.....	.....	13.5	87.0	125.0	105.3	.....		.....	187.2	.....	.....	38.4	181.8	(1000.0)	.....	.....
70 or over	70.3	.....	.....	.....	19.2	121.2	133.3	.....	.....		264.6	.....	.....	640.0	133.3	.....	.....	.....	.....

* Per 1,000 exposures.

† On an annual basis.

TABLE 5. DISCHARGES AMONG FIRST ADMISSIONS WITH GENERAL PAROSIS TO THE NEW YORK CIVIL STATE HOSPITALS, FISCAL YEARS 1943-1944
TO 1946-1947 INCLUSIVE, WITHIN TWO YEARS AFTER ADMISSION, CLASSIFIED ACCORDING TO CONDITION AT DISCHARGE

<i>Condition at Discharge</i>	<i>Males</i>			<i>Females</i>			<i>Total</i>		
	Number	Percent of Total Discharges	Percent of First Admissions	Number	Percent of Total Discharges	Percent of First Admissions	Number	Percent of Total Discharges	Percent of First Admissions
Recovered	95	21.2	5.3	40	19.4	6.1	135	20.6	5.6
Much improved	233	52.0	13.1	104	50.4	16.0	337	51.5	13.9
Improved	90	20.1	5.1	51	24.8	7.8	141	21.6	5.8
Unimproved	30	6.7	1.7	11	5.3	1.7	41	6.3	1.7
Total discharges	448	100.0	25.2	206	100.0	31.6	654	100.0	26.9
Total first admissions	1,780	.....	....	651	.....	....	2,431	.....	....

sion. The total percentage discharged as improved increased from 8.8 during the earlier epoch to 25.3 percent among the later cohorts. Those discharged as unimproved decreased from 5.5 to 1.7 percent. Both sexes shared in percentage of improvement. Thus, recoveries increased among males from none to 5.3 percent; total improvement increased from 11.1 to 23.5 percent. Recoveries increased among females from none to 6.1 percent, and all degrees of improvement increased from 17.5 to 29.9 percent.

MORTALITY

Table 6 shows the average percentages of the cohorts dying within five years after hospitalization. Of the males, 47.2 per-

TABLE 6. FIRST ADMISSIONS WITH GENERAL PARESIS TO THE NEW YORK CIVIL STATE HOSPITALS DYING WITHIN SPECIFIED PERIODS AFTER ADMISSION, CLASSIFIED ACCORDING TO PERCENTAGE AND RATE

Period of Hospitalization	Males			Females		
	Cumulative		Rate per 1,000 Exposures *	Cumulative		Rate per 1,000 Exposures *
	Per- cent	Per- cent		Per- cent	Per- cent	
First three months.	19.3	19.3	792.6	15.6	15.6	637.4
Second three months	7.8	27.1	404.7	4.3	19.9	218.9
Third three months.	3.9	31.0	230.2	2.7	22.6	142.8
Fourth three months	3.2	34.2	202.3	3.3	25.9	185.1
First year	34.2	34.2	351.8	25.9	25.9	266.9
Second year	6.1	40.3	122.6	4.0	29.9	72.0
Third year	3.4	43.7	114.1	4.7	34.6	130.8
Fourth year	2.2	45.9	95.7	2.7	37.3	101.0
Fifth year	1.3	47.2	67.4	1.6	38.9	61.9

* On an annual basis.

cent died during this period. The heaviest mortality occurred during the first year, during which the deaths amounted to 34.2 percent of the total admissions. Within the first year, the heaviest mortality occurred during the first three months. Unlike discharges, the great majority of which occurred during the second year after admission, there were relatively few deaths after the first year. Only 6.1 per cent of the male cohort died during the second year, and the percentage dropped still further to 1.3 during the fifth year.

There was a similar trend among females, though at a lower level. Thus, 15.6 percent of the female first admissions with

general paresis died within three months after admission. A fourth of the total female cohorts died during the first year after admission. Only 4.0 percent died during the second year. The total mortality over the period of five years represented 38.9 percent of the cohorts.

It was shown previously that discharges have risen very significantly among first admissions with general paresis over the past four decades. A similar improvement occurred with respect to mortality. Thus 78.3 percent of the male first admissions with general paresis died within five years after admission circa 1910,⁵ compared with 47.2 percent in 1944-1949. For females, the corresponding percentages were 62.5 and 38.9 respectively. It is of interest that the improvement in mortality did not occur until after the first three months. During this period, 19.0 percent of the male first admissions of the earlier epoch died, compared with a current percentage of 19.3. Among females, the corresponding percentages were 14.0 and 15.6 respectively. In all subsequent periods, however, the current rates of mortality were lower.

Table 6 also shows the actual rates of mortality per 1,000 annual exposures. The heaviest mortality among males, 792.6 per 1,000 exposures, occurred during the first three months. The rate declined during the remainder of the first year, and averaged 351.8 for that period. The rate continued to decline after the first year, and reached a minimum of 67.4 during the fifth year.

Among females, the death rate reached a maximum of 637.4 per 1,000 annual exposures during the first three months, decreased subsequently, and averaged 266.9 for the first year. The death rates fluctuated fortuitously after the first year, though at a lower level, and terminated with a rate of 61.9 during the fifth year.

Improvement in rates of mortality were noteworthy. The male cohort of 1909-1910 had a rate of 446.0 per 1,000 exposures during the first year of hospitalization.⁶ The current male cohorts had a corresponding rate of 351.8. During the second year of hospitalization, the corresponding rates were 399.3 and 122.6 respectively. Similar decreases occurred during the remaining years of hospitalization.

There were similar improvements among females. For the

TABLE 7. RATES OF MORTALITY * AMONG FIRST ADMISSIONS WITH GENERAL PARALYSIS TO THE NEW YORK CIVIL STATE HOSPITALS DURING SPECIFIED PERIODS AFTER ADMISSION, CLASSIFIED ACCORDING TO AGE AT FIRST ADMISSION

Age at admission (years)	Males										Females									
	1st three mos.†	2nd three mos.†	3rd three mos.†	4th three mos.†	1st year	2nd year	3rd year	4th year	5th year		1st three mos.†	2nd three mos.†	3rd three mos.†	4th three mos.†	1st year	2nd year	3rd year	4th year	5th year	
Under 25.	132.8	137.9	158.4	428.6	163.9	66.7	66.7	66.7	66.7		316.8	180.8	180.8	180.8	190.4	156.9	156.9	156.9	156.9	200.0
25-34.	375.0	142.2	158.4	74.6	163.9	42.9	85.7	85.7	85.7		102.2	107.8	111.1	111.1	228.6	128.2	45.4	100.0	222.2	.....
35-44.	339.8	137.6	72.0	74.6	147.9	42.9	85.7	85.7	85.7		155.3	221.4	176.4	176.4	63.2	144.7	100.0	186.0	.....	.....
45-54.	561.4	354.4	138.4	41.4	247.7	105.3	114.3	101.7	62.5		369.7	139.1	48.7	48.7	49.4	144.3	57.1	58.8	66.7	.....
55-64.	642.7	209.4	128.2	115.9	249.7	109.0	100.6	58.8	.....		569.0	81.2	41.7	41.7	42.1	176.4	17.5	72.7	.....	90.9
65-74.	817.3	340.4	180.9	159.1	331.6	92.9	87.5	48.8	.....		632.0	246.2	175.8	175.8	92.9	261.6	68.8	115.9	187.5	142.9
75-84.	950.1	452.4	246.0	154.4	389.0	119.0	113.8	153.8	76.9		573.1	192.8	151.9	151.9	263.2	264.0	90.9	60.6	83.3	.....
85-94.	972.4	653.6	492.8	499.5	504.4	116.8	169.4	125.0	.....		(1000.0)	254.7	.....	.....	372.1	425.5	145.4	66.7	190.4	.....
95-104.	969.0	601.0	428.1	484.3	490.1	224.1	254.0	173.9	333.3		998.0	444.4	409.0	409.0	601.5	491.5	122.4	322.6	200.0	.....
105-114.	(1000.0)	597.0	491.2	320.0	537.3	285.7	125.0	105.3	500.0		(1000.0)	519.0	200.0	200.0	421.1	477.6	333.3	.....	.....	.....
115-124.	(1000.0)	(1000.0)	540.5	750.0	653.6	480.0	133.3	750.0	.....		(1000.0)	615.4	(1000.0)	(1000.0)	(1000.0)	727.3	.....	500.0	.....	.....

* Per 1,000 annual exposures.

† On an annual basis.

first year of hospitalization, the rates were 376.8 and 266.9 for the early and current cohorts respectively. During the second year, they were 249.6 and 72.0 respectively. During the fifth year, they were 134.4 and 61.9 respectively.

The rates of mortality are shown in Table 7 in relation to age at first admission. The rates were highest during the first three months after admission. Within this period they rose rapidly with advancing age. Thus, for males, the rate was

TABLE 8. PERCENT OF FIRST ADMISSIONS WITH GENERAL PARESIS TO THE NEW YORK CIVIL STATE HOSPITALS REMAINING IN CONTINUOUS RESIDENCE AT END OF SPECIFIED PERIODS AFTER ADMISSION

<i>End of</i>	<i>Males</i>	<i>Females</i>
Third month	77.9	81.9
Sixth month	68.7	75.4
Ninth month	64.2	72.4
First year	60.4	68.3
Second year	33.4	38.6
Third year	25.3	29.3
Fourth year	20.0	26.0
Fifth year	16.9	23.9

less than 500 per 1,000 annual exposures among those aged less than 35. But the rate rose to over 900, as the age at first admission increased. Among the oldest age groups, the mortality was so high during this period that the entire cohort would have died in less than a year had the rate been maintained. During the first year of hospitalization, the rates increased with advancing age to a maximum of 653.6 among those aged 70 or over.

During the first three months after admission, the mortality rate rose among females from less than 300 at the younger ages to rates at advanced ages which would have been unity on an annual basis. The average rates were lower for the first year after admission, but they advanced steadily with age to a maximum of over 700 at 70 years of age or over. Because of the small numbers during the later periods of hospitalization, the rates fluctuated in a more or less random manner.

Of the male first admissions with general paresis, 77.9 per cent were still on the books after a continuous residence of three months. The reduction was due principally to the heavy mortality during this period. Mortality continued at a lower rate during the remainder of the year, and discharges showed

no significant increase, so that the cohort, which had decreased by almost 30 percent during the first three months, decreased only an additional 17 percent during the remainder of the year. At that point, 60.4 percent of the males were still on the books. During the second year, however, there was a rapid increase in the rate of discharges, so that only a third of the male cohorts remained on the books at the close of that year. With the slowing of the rate of discharge after the second year, the cohort decreased slowly to 16.9 percent of the original total at the end of the fifth year, as shown in Table 8.

Because of their lower rates of mortality, the female cohorts exceeded the male cohorts in number at all corresponding periods after admission. At the end of three months, 81.9 percent of the female cohorts were still continuously on the books, compared with 77.9 percent of the males. At the end of a year, the percentages were 68.3 and 60.4 for females and males respectively. By the end of the second year, the cohorts amounted to 38.6 and 33.4 percent respectively of the original female and male cohorts. At the close of the fifth year, a fourth of the females were still on the books, compared with a sixth of the males. The median durations were 19.4 months for females, and 16.6 months for males.

The vast improvement in the results of treatment of general paresis become evident when comparisons are made with the cohorts of the period 1909-1910.⁷ Among males of this period, 7.3 percent were on the books five years after admission, including those who had been readmitted during this period. On the same basis, the current male cohorts had a corresponding percentage of 19.2. For females, the corresponding percentages were 16.7 and 26.2 respectively. The principal result of the newer therapies, therefore, was to increase the longevity of general paretics, as evidenced by their ability to live longer in hospitals.

SUMMARY

This analysis is based upon a series of five successive annual cohorts of first admissions with general paresis to the New York civil state hospitals. The first cohort was admitted during the fiscal year ended March 31, 1944, and the hospital history of each member of the cohort was followed

for five years from the date of admission. The cohort for the fiscal year ended March 31, 1945 was followed for a period of four years from the date of admission. There was a reduction of a year in the period of exposure of each successive cohort, until the final cohort, for the year ended March 31, 1948, gave an exposure of only one year. The rates of discharge and mortality over specified periods of time following first admission are therefore averages, based upon the cohorts who were under exposure during the corresponding periods.

The five cohorts included a total of 2,923 first admissions with general paresis, of whom 2,140 were males and 783, females. During the five years, 31.2 percent of the males were discharged from the books. The majority, 19.9 percent, were discharged during the second year after admission. There were relatively few discharges during the first year or after the second year. Similarly, among females, there were few discharges either before or after the second year. The total discharges averaged 37.2 percent of the female first admissions. A fourth of the females were discharged during the second year. As few general paretics are placed in convalescent care, the preceding percentages of discharge are equivalent, for practical purposes, to discharges directly from the hospitals.

The rate (or probability) of discharge was high during the first three months after admission but decreased steadily during the remainder of the first year. The rates reached a maximum during the second year for both males and females but dropped rapidly thereafter to minima during the fifth year of hospitalization.

A similar analysis was made of a cohort of first admissions with general paresis to the New York civil state hospitals during 1909-1910. Comparisons with this early cohort establish important contrasts. Thus, only 13.5 percent of the early male cohort were discharged within five years after admission, compared with 31.2 percent of the cohorts of 1944-1948. The corresponding percentages for females were 20.5 and 37.2 respectively. Furthermore, most of the discharges among the early cohorts occurred during the first year after admis-

sion. Only 2.5 percent of the males and 4.2 percent of the females were discharged during the second year. The later and contemporary cohorts, on the contrary, provided few discharges during the first year; the great majority of such discharges occurred during the second year. The newer chemotherapies necessitate long periods of treatment, which result in discharges at later periods. Finally, not only were there more discharges among the current cohorts with general paresis, but they now include higher percentages of improvement. Thus, 5.6 percent of the current cohorts were discharged as recovered within two years after admission, compared with no recoveries among the earlier cohorts. Those discharged as much improved included 13.9 and 2.3 percent respectively. Only 1.7 percent of the current cohorts were discharged as unimproved, compared with 5.5 percent of the earlier cohort.

Despite improved therapies, mortality still remained relatively high. A fifth of the male cohort died within three months after admission, a third died within a year, and almost half died within five years. Mortality was lower among females; nevertheless a fourth of the cohort died within a year after admission, and the total mortality within five years grew to almost 40 percent.

Compared to corresponding rates of mortality among cohorts admitted four decades earlier, the improvement is striking. Thus, among males, the present mortality of 34.2 percent of the total first admissions after a year of exposure compares with 42.7 percent of the earlier cohort, and at the end of five years the corresponding percentages were 47.2 and 78.3. In the case of females, the percentage dying within a year after admission was reduced from 35.2 to 25.9, and the total mortality within five years was reduced from 62.5 percent to 38.9 percent.

At the end of the fifth year after admission, there were relatively more general paretics on the books among the current cohorts than was formerly the case. Thus, 19.2 percent of the males and 26.2 percent of the females, including readmissions, were still on the books at the end of this period, compared with corresponding percentages of 7.3 and 16.7 four decades ago. The larger percentage of general paretics remaining alive and residing in the hospitals is responsible for

the growth in the absolute number of such patients in the hospitals, despite the fact that there has been a significant downward trend in first admissions with general paresis, and an increase in the rate of discharge.

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1. "Expectation of Hospital Life and Outcome for Mental Patients on First Admission," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, No. 2, April 1930, p. 312.
2. *Ibid.*
3. Rates of discharge computed from data in reference 1, p. 312.
4. "Hospital Departures and Readmissions Among Mental Patients During the Fifteen Years Following First Admission," by Raymond G. Fuller. *Psychiatric Quarterly*, Vol. 4, No. 4, October 1930, p. 658.
5. See reference 1, p. 306.
6. Rates of mortality computed from data in reference 1, p. 306.
7. See reference 1, p. 301.

TWO INTERNATIONAL CRIMINOLOGIC CONGRESSES: A PANORAMA*

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THE LONDON CONGRESS ON CRIMINOLOGY

THE Third International Congress on Criminology in London dealt with a more unified topic than did the United Nations assemblage at Geneva; namely, *recidivism*. It was characterized also by a greater representation of researchers, scholars, and practitioners and a lesser emphasis on political and governmental representatives than was the Geneva meeting. Some 400 members, drawn from 52 countries, attended.

Five sections, each under two General Reporters, dealt with the topics of *Definitions of Recidivism and Their Statistical Aspects*, *Descriptive Study of Forms of Recidivism and Their Evolution*, *Causes of Recidivism*, *Prognosis of Recidivism*, and *Treatment of Recidivism*. Numerous individual reports prepared by invited scholars representing different countries were submitted to the ten General Reporters, who condensed these contributions, commented on them and arrived at conclusions, recommendations, or resolutions. The general reports were discussed at the section meetings and the outcomes of these discussions were laid before the entire body at the plenary sessions, not so much for voting and adoption as for presenting, as it were, "the sense of the meeting." In addition, certain individual papers and lectures were delivered both in section meetings and at plenary sessions before the assemblage as a whole.²⁰

* Part II of a two-part paper.

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²⁰ The papers and lectures included the presidential and closing addresses by Dr. Denis Carroll, "The Individualization of After care" by Dr. Vladimir Hadzi, "Case History of a Recidivist Thief" by Dr. L. Rubenstein, "Correlation between Recidivism and Functional or Anatomical Changes in the Brain" by Dr. Hrousseau, "The Status of the Glueck Prediction Studies" by Dr. Eleanor T. Glueck, "The Treatment of Recidivism" by Dr. Marcel Freym; a symposium on homicide presented at a plenary session and consisting of "Psychosociological Study of Murderers in Sweden" by Prof. G. Rylander, "Emotional Reaction of Arrested Murderers to Their Crime, Their Trial and Their Sentence" by Dr. J. A. Holton, "Murderers and Their Victims" by Prof. M. Wolfgang; a plenary session preview of a forthcoming volume on "Physique and Delinquency" by Prof. Sheldon Glueck

Since the constituent papers of the sections other than Section IV (of which the writer was one of the General Reporters) are not available, discussion must be confined to the General Reports.

VI

Section I dealt with the *Definitions of Recidivism and Their Statistical Aspects*, for which the General Reporters were Professor Roland Grassberger (Austria) and Professor Norval Morris (Australia). Dr. Grassberger²⁷ devoted his paper largely to statistical problems and presented a series of charts and graphs illustrating such matters as the criminality of recidivists in the total body of criminalism, the role of "accidental criminals," the "dynamic" of recidivism, punishment and recidivism, the success of the sentence administered, study of the criminal career. He noted the impossibility of any

and Dr. Eleanor T. Glueck; "specialist meetings" consisting of papers on "Sex Offenders and Recidivism" by Dr. G. B. Smith and "Sex Offenders—A Team Study" by Dr. Bernard Glueck, Jr. (read by Mrs. Isa Brandon, a member of the research team involved), "International Aspects of Forgery of Works of Art" by Prof. T. Würtemburger, and "Recidivism and Banknote Forgery" by Prof. F. Castejon; lectures on "An Anthropometric Study of Young and Adult Offenders" by Profs. M. Verdun and G. Heuyer, "Masked Schizophrenic Reactions and Persistent Criminal Behavior" by Dr. R. Banay, "The Criminality of Unpunishables" by Prof. V. V. Stanciu, "Specialized Methods and Techniques in the Psychotherapy of Delinquents" by Dr. M. Schmideberg, "Ductless Glands and Recidivism" by Prof. C. V. Ferreira; "Maconochie—An Early Pioneer of Penal Treatment" presented at a plenary session by Justice J. V. Barry of the Supreme Court of Victoria, Australia; "Frontiers of Research in Criminology" by Prof. Marshall B. Clinard, and "The Psychological and Penological Aspects of Various Types of Recidivism" by Dr. Gregory Zilboorg, both presented at a plenary session; lectures on "The Psychological Background of Recidivism" by Dr. H. Ritey, "Clinical Standards of Prognosis in Juvenile Delinquency—An After-history Study" by Dr. A. Bonnard, "Public Attitudes towards Stealing" by Prof. E. Smigel, "The Legislator and the Problem of Recidivism" by G. Koskoff, "The Treatment of Recidivism and the Attitude of the Public" by Dr. Leon Stern, "Recidivism in Narcotic Addiction" by Dr. H. Berger. In addition there were the usual welcoming and closing speeches by various dignitaries. Because of the great interest in the Glueck prediction techniques, Mrs. Glueck, on invitation, held two special sessions explaining the techniques.

²⁷ Grassberger, R., *Les Définitions de la Récidive et leur Importance pour les Statistiques*, Rapport Général, Section I, Troisième Congrès International de Criminologie, Londres, 12-18 Septembre 1955. Some of the material mentioned in the text was derived from the English digest of the general reports, *Summary of General Reports*, Sections I-V, Third International Congress of Criminology, London, 12th-18th September, 1955. It is not known whether the summary of his paper was prepared by Prof. Grassberger himself.

single or uniform definition of recidivism, the term being used according to its context and the point of view of the person (doctor, lawyer, statistician) concerned. He adverted to legal differentiations according to such criteria as the time elapsing between the prior and subsequent offense, the similarity in types of offense or variations in offense indicative of the same underlying tendency; the fact that definitions in recent legislation take into account the original offense and its "inner connection" with the subsequent offense as indicating an "asocial penchant" and prescribe severer sanctions therefor. Through adequate statistics "the legislator can be informed about the degree of recidivism in various types of offenses, the penal administrator can check the success of his measures, and the policeman can get information regarding the likelihood of offenders who specialize in one type of crime switching to a different offense."²⁸ Current official statistics cannot, however, furnish adequate data for special, intensive research, involving the detailed study of case histories. The condition *sine qua non* for all statistics on recidivism is a "*casier judiciaire*" which operates according to a plan that deals with problems not merely retrospectively, centering upon the past of the offender, but prospectively, following the offender during his career after conviction.²⁹

During the discussion of Grassberger's report, it was brought out that an important development in official statistical material in the different countries is "a trend from descriptive statistics to operational research, i.e., to statistics related to action."³⁰ The following resolution was unanimously adopted by the Congress:

"Be It Resolved: That the Congress recommend that a committee be appointed to examine the data on recidivism in the official criminal statistics of various countries and to prepare a report suggesting minimum objectives and standards for the collection and publication of such data."³¹

It was further agreed that "such a committee could be formed by the International Society of Criminology and that detailed

²⁸ *Summary, op. cit.*, p. 3.

²⁹ *Les Définitions, etc., op. cit.*, pp. 19-20.

³⁰ *Memorandum of Conclusions of Third International Congress on Criminology 1955, London. Mimeographed.*

³¹ *Ibid.*, p. 2.

suggestions of individual members should be made to the Society."³²

Professor Morris confined his paper to the always baffling task of definition. He noted a "surprising similarity of approach" on the part of the thirteen contributors to his symposium. He presented the following "somewhat contentious propositions":

"that it is both impossible to achieve and unwise to seek a single definition of recidivism;

"that we must define recidivism differently for the purposes of at least three different aspects of the application of the criminal law;

"that recidivism has a different connotation to the lawyer, the penal administrator, and the criminologist, when considered from the viewpoint of their own disciplines; and

"that though there are elements in common in these three types of definition of recidivism they are too few to form the foundation of any useful single definition."³³

Following the propositions noted, Professor Morris analyzed the penal, the legal, and the criminologic definitions of recidivism, noting their individual relevancy to these respective areas and citing examples from a wide variety of countries. His conclusion follows:

"The essential unifying concept behind recidivism is the repetition of crime after conviction. The penal administrator tends to test this by reappearance in prison; the lawyer by reappearance as a convicted person in court; while the criminologist desires to test it by the subsequent commission of crime. The penal, legal, and criminological definitions will all be narrowed by the interpolation of many other factors qualifying the personality of the offender and the type and number of his crimes and sentences; these will vary according to the particular proposition or inquiry concerning recidivism being made and will vary considerably from one legal system to another and from one criminological, legal, and penal inquiry to another."³⁴

In the deliberations of the section it was brought out that definitions vary with aim; that "every definition, either legal or criminological, can be regarded as a tool, as a means to apply legal sanctions or to organize research material. For that reason there must be a variety of definitions according to different laws, legal systems, and research requirements."³⁵

³² *Ibid.*

³³ Morris, N., *Definitions of Recidivism*, General Report, Section 1, Third International Congress of Criminology, London, 12th to 18th September, 1955, pp. 2-3.

³⁴ *Ibid.*, p. 16.

³⁵ *Memorandum of Conclusions, op. cit.*, p. 1.

The following statement was unanimously accepted at the plenary session:

"For different purposes the criminologists need different definitions of recidivism. Recidivism in the criminological sense, therefore, includes the following main forms. It means:

- (1) that a person after having committed a first crime which was legally established, and having been convicted of it or in any other way dealt with officially by society, then commits another crime (*recidivist stricto sensu*),
- (2) that a person having committed a first crime legally established and dealt with as before resumes his criminal activity because of his 'dangerous state' (*recidivist lato sensu*)."³⁶

Discussion.—Dr. Grassberger's charts and graphs deserve study by all those interested in a system of administrative statistics that can keep its pulse on the processes of justice. Regarding the investigation into the subsequent careers of offenders, it is doubtful whether this can be effectively accomplished under governmental auspices. Reliance must be had on researchers in universities and institutes, since the techniques involved are complex and subtle and the researchers in follow-up studies must above all be neutral,³⁷ and not influenced by a propagandistic desire to prove the high effectiveness of certain penal regimes, or probation or parole.

Properly implemented by an active committee, the resolution of the Congress on statistics of recidivism can lead to fruitful results, especially in encouraging the development of operational statistics as an instrument of administrative control and for the guidance of policy in the light of measured results.

The adopted statement on the definitions of recidivism is hardly an improvement over Morris's down-to-earth approach which seems to the writer to be the only way of avoiding

³⁶ *Ibid.*

³⁷ Intensive and unbiased field investigations usually prove that the officially published failure rate is materially lower than the actual one. See, for example, the follow-up studies by Sheldon and Eleanor Glueck: *500 Criminal Careers*, New York, Alfred A. Knopf, 1930; *One Thousand Juvenile Delinquents*, Cambridge, Harvard University Press, 1934; *Five Hundred Delinquent Women*, New York, Alfred A. Knopf, 1934; *Later Criminal Careers*, New York, Commonwealth Fund, 1937; *Juvenile Delinquents Grown Up*, New York, Commonwealth Fund, 1940; *Criminal Careers in Retrospect*, New York, Commonwealth Fund, 1943; *After-Conduct of Discharged Offenders*, New York and London, Macmillan Co., 1945.

wasteful entanglements in a variety of differing concepts sailing, confusedly, under a single flag. It is the approach which those conducting the deliberations on the definitions of juvenile delinquency at the Geneva Congress should have taken to save time and ruffled spirits; for while working definitions are usually necessary to the focusing of an investigation, the nature of a definition depends on the aim and context of an intellectual exploration, and it is familiar wisdom that meaningful definitions develop toward the end of an inquiry rather than at its beginning.

VII

In Section II, which dealt with *Forms and Evolution of Recidivism*, Dr. C. H. Andersen (Belgium) and Professor Walter Reckless (U.S.A.) presented thought-provoking general reports. At the outset, Dr. Andersen³⁸ sketched the sources of motivation in instinctual equipment and early conditioning. He pointed out that an etiologic classification is possible according to the origin of the habits of an individual—instinctual, those derived largely through education, through example, through emotional conflicts, through frustrations, through integration in a group.³⁹ “The study of instinctual motives reveals two possible anomalies. Recidivism can be a habit of [original] impulse (*habitude pulsionnelle*), assuring an instinctual satisfaction not inhibited by the brake of socialization; it can be also a secondary habit, born of a poorly resolved conflict of impulse, that is, a neurosis.”⁴⁰ Andersen distinguishes no fewer than six types of classification of recidivists: *legal* (which is weak in that it ignores psychologic motivation); *descriptive* (which treats of a variety of repeaters under a single stereotype, ignoring the important fact that while like offenses reveal a similarity of criminal intent they may have a wide variety of motivations); *classification by criminal career* (contrasting those who recidivate because of bad social conditions, such as ostracism of the ex-prisoner, with the professional

³⁸ Andersen, C. H., *Formes et Évolution du Récidivism*, Rapport Général, Troisième Congrès International de Criminologie, Londres, 12-18 Septembre 1955, pp. 1-2.

³⁹ *Ibid.*, p. 2.

⁴⁰ *Ibid.*

recidivist of antisocial character); classification according to *psychologic type* (based on a character typology derived from temperamental or affective makeup, Andersen including here the comparative study of Rorschach Test and psychiatric traits by Sheldon and Eleanor Glueck—*Unraveling Juvenile Delinquency*⁴¹—which he regards as useful for both prognosis and therapy but which he claims is inapplicable to adults since their “character and the reactive potentialities have been modified by experience, by incident and by examples”);⁴² classification by *criminologic type* (Andersen pointing out that the method of psychologic analysis in the Gluecks’ work permits of determining types of probable recidivists through the isolation of certain constellations of factors among the numerous combinations of person-milieu, and listing various patterns); *psychiatric* classification (based not only on cognitive and affective anomalies but also on anatomic or physiologic determinants, including the findings of constitutional psychology, and involving the view that the tendency to recidivate despite punishment is essentially a congenital weakness).

This analysis of types of classification of recidivists is followed by a detailed consideration of different patterns of non-recidivists and recidivists from the point of view of practical correctional administration, somewhat along the lines of the typology suggested by Reckless (below), but with greater emphasis on psychiatric and psychoanalytic concepts, especially in discussing the role of the superego and ego. This practical classification of recidivists is first broken down into four types who are neither rendered more wise nor intimidated by the punishment they have undergone and four types who are influenced thereby.

He ends with a stirring plea for the study of personality in both its mental and physical aspects and under the impact of the environment.

Professor Reckless⁴³ emphasized the great need of case-history preparation and analysis as a complement to mass statistical studies. He posed the questions whether a stand-

⁴¹ New York, Commonwealth Fund, 1950.

⁴² See *Discussion of materials on Prognosis*.

⁴³ Reckless, W. C., *The Forms of Recidivism*, General Report, Section II, Third International Congress of Criminology, London, 12th to 18th September, 1955.

ard outline should be developed and used for the systematic collection of case-histories of recidivists; whether this should be done by research teams, "representing several methods and approaches"; what comprises "an adequate sample of case-histories which can give authority and validity to the findings of criminologists?" and "what are the case-history criteria of a recidivist?" He suggested as basic criteria, "the meaning or function of the recidivistic behaviour in the individual case-history" and the "dominant etiologic factor in the individual case-history." He said that there are patterns of recidivism reflecting a criminal career or vocation and those "representing the uncontrollable repetition of criminal acts, which . . . are merely the behavior of . . . habitual and abnormal delinquents and criminals." Like Andersen, Reckless submitted a thought-provoking breakdown of the general area into principal patterns of recidivism, but his system takes more account of sociologic concepts:

(a) *Criminal careers, vocations, or trades*, divided into (1) ordinary criminal career ("a mixture of gainful property crimes," which emerge out of bad environments, social and economic inadequacies, criminal associates, etc.); (2) criminal trades of a "special group tradition," such as "moonshiners," gypsies, etc., the recidivist here acquiring the criminalistic pattern "as a perfectly normal member of his special social group"; (3) organized criminals (gangsters, racketeers, traffickers in women and drugs, criminal receivers, etc.), these following "the route of those in pattern 1 until they make connection with definitely organized criminal enterprise"; (4) professional criminals (confidence men, forgers, counterfeiters, etc.), who have not "emerged out of pattern 1 but rather have middle class origin," have developed an anti-social expression of their skills "as a result of contact with other professionals," stay aloof from ordinary criminals, and often manage to keep out of prison; (5) the middle and upper class white-collar criminals, or violators of positions of trust and governmental controls, who also usually manage to escape imprisonment and who recidivate because of the "lure of great gains at little risk, the example set by dishonest and unscrupulous colleagues, the failure to get caught." (The extent of patterns 3 and 5 depends greatly on the "particular

development of business, the professions, and government service in various countries.") (6) The physically handicapped, driven into crime by inferiority feelings or difficulty in making an honest living.

(b) *Habitual and abnormal offenders* comprise (7) the anti-social characters (of "weak ego structure and weak internal controls," and of "very little superego (conscience)" and capacity to identify with others, who "renege on their social and economic obligations, often gravitate to alcoholism, drug addiction, vagabondage, and frequently become sexual deviates." This group includes the "psychopaths." (8) Psychoneurotic delinquents and criminals, "usually acting from compulsion . . . but sometimes acting from anxiety tensions. . . . The psychoneurotic offender does not want to be criminal. Criminal breakthrough increases the neurotic's anxiety but at the same time discharges his more basic tensions." (9) Habitual delinquents and criminals deriving from such pathologic conditions as epilepsy, postencephalitis, brain injury, etc., who are often confused with persons falling in pattern 7; (10) Abnormal recidivists due to psychosis or mental defect.

Recognizing that there is some overlap in this typology and that such a list might not apply as much in one country as another, Reckless asked whether the Congress should "accept the principle of identifying and distinguishing the principal forms of recidivism according to function (meaning) of the behavior and dominant etiological factor as shown in the case-history of each recidivist. If not, should some other criteria for identifying forms of recidivism be used?"

Finally, Reckless proposed "a central theme of study which gives perspective, meaning, and significance to all contributions"; namely, the assessment of the individual along a continuum of socially acceptable conduct, according to the extent of his "capacity or incapacity to play acceptable roles in life." Thus "due to the components which have contributed to his socialization or asocialization . . . an individual may be a saint upon earth, a very conventional person, a good citizen, a wayward person, a delinquent, a recidivist, or an uncontrollable deviate. He might have expectancy to maintain his position on the continuum of socially acceptable behavior or he might have expectancy to improve or retrogress, accord-

ing to the interaction of the components of his personality with the demands of his immediate social environment."

The *Conclusions* unanimously adopted by the Congress divide recidivists into professional, sophisticated offenders and those whose repeated criminalism is essentially due to their social and psychologic maladaptation.⁴⁴ The *Conclusions* aver that criminology is as yet unable to give a "valid explanation" of the etiology of recidivism, limiting itself essentially to a symptomatic description. Nevertheless, such a typology has considerable importance for prevention and treatment. "The scientific study of recidivism must involve simultaneous research in different countries of the world with different groups of recidivists."⁴⁵ It is requested that the Scientific Commission of the International Society of Criminology establish a subcommittee to "study the scientific and practical conditions under which criminological research can proceed with teams of competent workers, using uniform lists of data in the collection of case-history information," in a way to permit of comparisons among the various countries and of "statistical graphing and analysis."⁴⁶

Discussion.—It would require too much space to go into detailed consideration of the typologies presented by the two General Reporters. Suffice it to say that their scope is both wide and deep, and that the psycho-social patterns underlying the classifications "ring true." They should serve as a source of fruitful hypotheses for the purposes of both treatment and research. Andersen's belief that predictive factors useful in forecasting delinquency on the part of children will not work with adults is something that only the passage of time can determine.

Conceived of as working hypotheses, Reckless's tentative patternings of the major types of criminalism suggest promising lines of research. Reliable case-histories can throw light on the extent to which the divergent paths of the various types of offender he describes have a common origin in the family matrix of the first few years of life and permit of tracing the intervening influences that operate in adolescence and later to incline the original, commonly maladjusted chil-

⁴⁴ *Memorandum of Conclusions, op. cit.*, p. 2.

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

dren toward one or another of several adult antisocial patterns. In this way much of the basic research tending to show a crucial influence of parent-child relationships in the *origins* of antisocial maladjustment,⁴⁷ might be reconciled with the basic researches emphasizing group, community, or class influences and specialization in anti-social conduct.⁴⁸

As to Reckless's proposed "central theme of study" for all criminologists, the writer is less certain. He cannot see that the emphasis on "role playing" in assessing the individual along a continuum of socially acceptable conduct greatly advances understanding of the phenomenon of antisocial behavior. Does it not merely substitute words for words? If the objective behavior be in issue, how does it improve matters to speak of the subject's "role" as father, parent, worker, worshiper, recreational companion? If the subjective attitude of the self toward the various activities involved in these objective behavioral outlets be in issue, how is the reference to "role playing" an improvement over ordinary clinical description and interpretation?

The *Conclusions* of Section II adopted by the Congress are valuable. However, in the writer's opinion they over-emphasize the alleged absolute difference between "symptomatic description" and "valid explanation." Explanation is, after all, refined description; and if symptomatic patterns are important to understanding and efficiency in prevention and treatment of recidivism (as the *Conclusions* admit them to be), that is good enough even though "ultimate answers" (if there be such) are not as yet forthcoming. The distinction between "mere empiricism" and "scientific explanation" which some social scientists love to emphasize to prove they are really "scientists" is not as profound as it appears.

⁴⁷ For example, Hartwell, S., *Fifty-five "Bad Boys,"* New York, Knopf, 1931; Glueck, S. and E. T., *One Thousand Juvenile Delinquents*, Cambridge, Harvard University Press, 1934; Healy, W. and Bronner, A., *New Light on Delinquency*, New Haven, Yale University Press, 1936; Burt, C., *The Young Delinquent*, London, University of London Press, 1938; Bowlby, J., *Forty-Four Thieves*, London, Ballière, Tindall & Cox, 1947; Glueck, S. and E. T., *Unraveling Juvenile Delinquency*, New York, Commonwealth Fund, 1950.

⁴⁸ Such as Thrasher, F. M., *The Gang*, Chicago, University of Chicago Press, 1927, 1936; Shaw, C., *Delinquency Areas*, Chicago, University of Chicago Press, 1929; Sutherland, E. H., *Principles of Criminology*, Chicago, Lippincott, 1955 (fifth edition); Clinard, M., "Secondary Community Influences and Juvenile Delinquency," *The Annals*, January, 1949, pp. 42-54.

The establishment of a subcommittee to bring some standardization into the gathering of case-history data should help to establish a comparative criminology.

VIII

In Section III, on the *Causes of Recidivism*, Professor P. A. H. Baan (Netherlands) was the General Reporter.⁴⁹ Baan begins his report by asking whether recidivists are (a) those who have repeatedly fallen afoul of the law, or (b) those who, whether they fall "into the arms of the law or not," repeat actions which render them liable to punishment, or (c) those who have "more than once offended against the general standards on which a well-organized community is based."⁵⁰ He points out that group (a), which is the one usually studied, represents but a very small fraction of humanity; that "95 percent of all human beings have never come into contact with the law as the result of any crime," an astonishing yet too little noticed fact; and that since "nearly everyone whose social life is governed by regulations and standards" (such as those in the Ten Commandments) "has a constant tendency to infringe these standards," it is "unjust" to exclude them from the discussions of the Congress even though they remain out of the reach of the law and largely out of the scope of our knowledge. He raises the question whether there is a fundamental difference or only one of degree between the (a) recidivists and the (b) and (c), especially the last.

Baan claims that since "the essence of every '*einmalige*' conduct or misconduct (*i.e.*, performed once only), its underlying normal or abnormal mental state, is still . . . only seldom considered and elucidated," a prognosis or prediction on the material in the researches is impossible.

Referring to a six-year intensive psychiatric study of a thousand recidivists in The Netherlands, during which each was "very closely observed daily for a period of six weeks

⁴⁹ Although the program also lists Prof. J. J. Panakal (India) as a General Reporter, the writer has not received a copy of Panakal's report, if it was submitted. The *Summary of General Reports* does not include any digest of a paper by Panakal.

⁵⁰ Baan, P. A. H., *Causes of Recidivism*, General Report, Section III, Third International Congress of Criminology, London, 12th to 18th September, 1955.

to two or three months, by a staff of male and female nurses, while psychiatrists, psychologists, a physician, and social workers were able to carry out their very precise examinations against the background of a carefully prepared anamnesis . . . and an accurate description of the hereditary and environmental circumstances," Baan says that the results thus far justify his taking a stand "against the too-crude stating of superficial diagnoses and the all-too-easy assumption of the existence of endogeny, psychopathy, and other incurable conditions" (a modern research position "steeped in the blackest pessimism"); and he gives some illustrations, based on the proposition that "going back as far as birth, psychogeny and sociogeny cannot be separated from any possible components of predisposition." Thus, of 100 persons admitted to his hospital as psychopathic "only 10 at most were psychopathic in a strict sense; 90 or more of those who were termed psychopaths owing to disturbances of conduct, turned out not to be so, though the disturbances in adaptation from which these delinquents suffered showed strong resemblance to the symptoms of the original conceptions of psychopathy." He raises the question "whether it will ever be possible to separate endogeny on the one hand and psychogeny and sociogeny on the other. Further scientific research, which will be costly both in time and trouble, will shed more light on this question."⁵¹ As with psychopaths so with mental defectives, *insanis moralis*, and "the fairy tale, the myth of the professional criminal." In all these, the nature-nurture puzzle prevails.

Neglect (including pampering) "proved indeed to be an important factor" in the research; and a basic discovery is that the criminal records are not homogeneous, so that in a "series of economic offenses one may find an aggressive or a sexual offense, or both, and when a criminal record does happen to be homogeneous, thorough psychiatric, psychological, and social investigation nevertheless indicates that there are also deep-lying disturbances in the other spheres of the personality."⁵² Dr. Baan's striking descriptions of person-

⁵¹ *Causes, etc., op. cit.*, p. 6.

⁵² *Ibid.*, pp. 8-9.

ality and of the influence of childhood *neglect* on antisocial behavioral tendencies deserve quotation:

"In general one could say that for the optimal functioning of man in society, an integration and a fine regulation of a great variety of biological, somatic, and psychical components are necessary . . . if the individual is to hold his own in the world in his interactions with other people, and to take part in it in a positive sense as well. Owing to the normal and adequate development of factors which at present we clumsily explain in concepts of intellect, feeling, intuition, instinct, emotionality, etc.,—though it is only through contact with others that these become facets of the entire personality of the individual in his interaction with the world—an infinitely fine combination of factors is created, a regulative system and organism, capable of realizing intangible concepts such as love of one's neighbor, fidelity, responsibility, feeling of guilt, etc. . . . It may be . . . that the one who did wrong did not happen to possess such a highly integrated regulative mechanism that the development of responsibility and therefore of accountability was possible. And here . . . the factor of neglect comes into play. In the same way as organic neglect—lack of vitamins, albumen, carbohydrates, fats, calories, iron, nitrogen, and innumerable other constituents—can have the most serious and disastrous results for normal development, the shortage of constituents indispensable for the normal development of the psychical personality, such as love, affection, warmth, cherishing, safety, etc., can have the most marked and disastrous results. In the same way as the body, the psychical personality can remain defective or can become distorted and acquire all kinds of other symptoms which make it impossible for him to accept responsibility like the average person, to love his neighbor, to be faithful, etc. All these things can be seen in an endless number of so-called normal beings, who never come into contact with the psychiatrist or the judge. They can be seen, however, most frequently in criminals in general, and in recidivists in particular. Is this disease, is this disturbance? I do not know." 53

Drawing on several contributory papers and on his own psychiatric experience, Dr. Baan also has wise things to say about the administration of criminal justice:

"In prison, as well as during judicial proceedings, methods of treatment that are inadequate, inexpert, loveless, too severe or too mild, can create all sorts of possibilities, which the delinquent adopts to project his unassimilated feelings of guilt on others. An over-severe regime, the exclusion from the outer world, the senseless daily round, the bad treatment, insufficient, inadequate work and the abnormal situation of prison communities, all give insufficient opportunity for the feelings of guilt to ripen and to be assimilated, or for the offender to live through the crime committed, and to reach a catharsis. . . . Unsolved feelings of guilt tend on the one hand towards the repetition of forbidden actions within the framework of a guilt-punishment complex, on the other hand, to that crust formation that brings about a mask of sanity and turns the delin-

⁵³ *Ibid.*, p. 10.

quent into a quasi-hardened criminal. . . . The suitable punishment or treatment must satisfy two criteria. On the one hand it must take into account the very personal idiosyncratic nature of the rather exceptional individual who, presumably owing to his emotional disturbances, fails in his respect for the legal order. On the other hand, after satisfactory examination and diagnosis, it must above all things provide an opportunity for the feelings of guilt of the delinquent to ripen and be dissolved, and give him the chance to make up for his crimes by adequate adaptation to society. There he can make amends, whilst society also needs to make amends for so much to him. . . . If . . . we approach the offender from an unprejudiced, accepting attitude as a fellowman, our recognition of his individuality will not fail to draw out his individuality, though perhaps only after much patience and repeated efforts. Our confidence will finally reveal, slowly but surely, the still unimpaired responsibility under the ruined personality, and make him susceptible to a therapeutic approach which ought to be applicable in prisons as well as in therapeutic institutions. No threats, no enmity, but an approach which accepts him as a fellow-creature, both during the judicial stage and during the execution of the punishment or treatment. In this procedure, based on a sense of common humanity, the lawyer, psychiatrist, psychologist, sociologist, and social worker must be combined in a team, at a level where all of them have outgrown narrow professionalism, moved as they are by their compassion for their fellowman who has sinned against this legal order, which, too, is in need of their compassion."⁵⁴

Dr. Baan naturally regards it as "unjust to make recidivism a reason for increasing the length of punishment." He is convinced that recidivism will be materially reduced "if careful observation, accurate selection before relegation to differentiated prisons and institutions, and careful, very expert treatment by large staffs of psychiatrists, psychologists, sociologists, ministers of religion, social workers, together with good nursing and penitentiary personnel, are all linked closely with a well-thought-out and expert after-care."⁵⁵

Research, says Dr. Baan, should not be limited to recidivists. "Particularly juvenile and first offenders urgently need our attention and care, because they may, unfortunately, be potential recidivists."

The lengthy *Conclusions* of Section III may be summarized in the following propositions: Recidivism "covers a variety of forms of conduct, and the individual cases . . . grow out of a complicated interplay between hereditary, personal, and environmental factors in ever-changing constellations."⁵⁶

⁵⁴ *Ibid.*, pp. 12-13.

⁵⁵ *Ibid.*, pp. 13-14.

⁵⁶ *Memorandum of Conclusions, op. cit.*, p. 3.

The concept of "cause" should be examined thoroughly, and it may prove helpful to use "the tools of modern analytic philosophy and semantics" in the process. Although the section sought to determine which traits of personality or social conditions distinguish the recidivist from both the first offender and the law-abiding citizen, it has been impossible to discuss the causes of recidivism apart from the causes of criminal conduct in general. The issue really is, "In what cases, and for what reasons, are the sanctions which society applies unable to counteract effectively the criminogenic factors involved."⁵⁷ Although a "common thesis" among criminologists has been that social factors play the dominant part in etiology of the casual offender while personality factors predominate among recidivists, this broad generalization is subject to numerous exceptions; evidently, mental disease and abnormal personality are more involved in grave and persistent recidivism than in casual offense; but there is little evidence that innate low-grade intelligence is important. Nor is the neurotic conscious or unconscious seeking out of punishment (associated with a pre-existing guilt feeling) frequently involved. There was an unresolved difference of opinion in the section as to whether professional criminals (*e.g.*, pick-pockets, car thieves, etc.) are essentially the product of the deliberate choice of a professional criminal career involving high gain with little risk, "together with a certain lack of moral standards," or (a view held by Professor Baan) they are rather the result of "emotional factors, such as hurt pride, disappointment, frustration, resentment, etc.," nobody deliberately choosing a criminal career "out of normal and rational considerations." A multidisciplinary attack on the problem of recidivism is necessary, in which psychologists, psychiatrists, sociologists, social anthropologists, lawyers, police officers, prison administrators, clergymen, and social workers need to cooperate.

Discussion.—Dr. Baan's thoughtful paper rightly warns against the intellectual blight of too hasty labeling and classification of personality. Yet his typical attitude of the "individual case" clinician appears to the writer as itself rather stultifying. One can only commend the call for more inten-

⁵⁷ *Ibid.*

sive and penetrating study of the individual case; but if each case is to be regarded as absolutely unique it is difficult to see how a science of Man can ever be developed. The scientist seeks uniformities and differences in masses of cases; but before he can use a thousand cases he must, like the clinician, be sure that each single case contains reliable and relevant data. Relevancy of course changes with the ever-deeper penetration of scientific exploration; but the pragmatic test of relevancy is *manageability*. If, for example, the predictive factors in a table in fact separate the sheep from the goats, then, crude as these factors may be, they serve a useful purpose, useful not merely for immediate administrative control but as a means of narrowing and defining areas for more intensive exploration.

Dr. Baan's views on penology are not only in the best humanitarian tradition but throw psychoanalytic light on the role of guilt feeling in the correctional and reformative processes. "Treatment" does not necessarily exclude the *therapeutic* need of emotional suffering. It is not the absence of all pain that is called for in the correctional regime (if, indeed, it were possible to achieve that), but rather the proper guidance of unavoidable suffering to bring about its constructive contribution to self-understanding and to personality growth. While not ignoring the most frequently cited causes of recidivism, such as the robotizing influences of penal institutions, the inadequate official aid to the ex-prisoner during the crucial early stages of his return to free life, and the unfriendly attitude of the public to the "jail bird," Dr. Baan gives glimpses of the deeper influences.

The *Conclusions* of Section III are certainly not earth-shaking. Typically, a feeling of inferiority on the part of criminologists is evident in their shying away from the idea of "cause" and in the call for aid from philosophy and semantics. The section seems to have overlooked the probability that the best approach to ideas of etiology in criminologic problems is the experimental one which checks on results in terms of treatment given in the light of operational assumptions that certain factors are causally implicated. In this connection, predictive instrumentalities are of value in nar-

rowing the field of intensive effort and in defining specific targets for correctional activity.

That cooperation between representatives of numerous relevant disciplines is necessary in reducing recidivism is so obvious as to require no reiteration.

XI

It is fair to say that Section IV, on the *Prognosis (and Prediction) of Recidivism*, of which Dr. Israel Drapkin (Chile) and the writer were the two General Reporters, aroused the greatest interest at the Congress. The importance of prediction methods was emphasized in the persuasive presidential address and closing remarks by Dr. Denis Carroll; Section I, which dealt with the *Definitions of Recidivism and Their Statistical Aspects*, included in its findings unanimously adopted by the Congress the statement, "In particular prediction techniques were advocated as the best method in order to decide on the type of treatment which would suit the individual offender";⁵⁸ the great interest in prediction devices called for extra sessions to discuss techniques. A special issue of the *British Journal of Delinquency*⁵⁹ was published; a book dealing with prediction was brought out⁶⁰ though not in time to be the subject of discussion. It is obvious that the rather cavalier treatment of prediction devices in the United Nations Congress at Geneva was not followed by the International Congress on Criminology in London.

Dr. Drapkin⁶¹ left the discussion of prediction tables in prognosis to his fellow reporter and devoted himself to the clinical approach. Even with the clinical approach, he suggested accuracy in prognosis can be aided by a scheme employing three sets of prognostic factors: (a) the life experience of the offender, including hereditary, familial, and personal background and criminal record; (b) the offender's

⁵⁸ *Memorandum of Conclusions, op. cit.*, p. 1.

⁵⁹ Vol. VI, No. 2, September, 1955.

⁶⁰ Mannheim, H. and Wilkins, L. T., *Prediction Methods in Relation to Borstal Training*, London, H. M. Stationery Office, 1955.

⁶¹ Drapkin, I., *Pronostico del Recidivismo*, Informe General, Seccion IV, Tercer Congreso Internacional de Criminologia, Londres; 12-18 Septiembre 1955. The textual statement of Dr. Drapkin's position is derived largely from the *Summary of General Reports, op. cit.*, pp. 19-20, and from the writer's recollection of Dr. Drapkin's statements at the section meetings.

personality as determined by clinical examination, particularly morphological, physiological, and neuropsychiatric findings; (c) intra- and extra-institutional therapeutic possibilities and the personal and social conditions to which the ex-prisoner returns. Taking into account the perpetual fluctuations in the two basic sets of variables—the individual and the *milieu*—Dr. Drapkin discussed the limitations of prognosis and emphasized the “unique experience” that is produced by the interaction of person and environment.

Only through teamwork can the most difficult task of criminology—prognosis—be accomplished. He would not rule out prediction tables as one of the techniques to be employed, recognizing that they are statistical refinements of a process that the experienced clinician goes through more impressionistically in prognosticating on the individual case.

Exceptionally fine papers⁶² were submitted to the writer for his general report on the *Prognosis of Recidivism*.⁶³ The General Reporter discussed the subject under the topics of the Nature and Extent of Recidivism, “Prognosis” and “Prediction,” The Uses of Predictive Tables, Objections to the Use of Predictive Tables as Instruments of Prognosis, Improvement of Predictive Devices and Resolutions on prognosis of recidivism to be presented to the Congress.

The first topic needs no discussion, since it formed the subject-matter of other sections. As to the second, the writer

⁶² In alphabetical order, the individual reports were submitted by the following contributors: Dr. Eleanor T. Glueck, research associate, Harvard Law School, Cambridge, Mass. (U.S.A.); Dr. Auguste Ley, honorary professor of psychiatry at the University of Brussels (Belgium); Dr. Elie D. Monachesi, professor of sociology, University of Minnesota, Minneapolis, Minn. (U.S.A.); Dr. Lloyd E. Ohlin, director, Center for Education and Research in Corrections, University of Chicago, Chicago, Ill. (U.S.A.); Mr. W. H. Overbeek, avocat-général près de la Cour d'Appel à Amsterdam (Netherlands); M. Jean Pinatel, secretary-general, International Society of Criminology, Paris (France); Dr. Peter Scott, physician, Maudsley Hospital, and psychiatrist, London Remand Home, London (England); Dr. R. S. Taylor, senior psychologist, H. M. Prison, Wandsworth (England); Dr. Estaban Valdes-Castillo y Moreira, professor of legal medicine, University of Havana (Cuba) and Dr. Eduardo Valdes Santo Tomas, president of the Council for the Direction of the Prison of Havana and professor of the National Penitentiary School (Cuba); Prof. J. M. Van Bemmelen, Leiden (Netherlands); Mr. L. P. Wilkins, London (England).

⁶³ Glueck, S., *Prognosis of Recidivism*, General Report, Section IV, Third International Congress of Criminology, London, 12th to 18th September, 1955.

pointed out that while prediction has come to denote the use of tables or charts in which the recidivism or non-recidivism of a large sample of offenders has been systematically correlated with the presence or absence of certain traits and factors in the makeup and background of those who have behaved satisfactorily as compared with those who have not, prognosis refers to the more impressionistic approach to the individual case by the clinician. Nevertheless, the two concepts have in common the fact that the clinician, too, relies on his past experience with numerous other cases in prognosticating on the case before him and the fact that both require a check-up, or validation, to see if their forecasts have been borne out by subsequent events. The European and Latin American contributors to the symposium on *Prognosis of Recidivism* tended to deal with prognosis in the clinical sense; the American, with prediction, involving the use of tables which summarize and objectify experience with hundreds of past cases.

Under the topic, the Uses of Prediction Tables, the General Reporter described the two basic methods employed in America—that of Burgess and that of the Gluecks—and adverted to various modifications. He then discussed the value of predictive devices (a) in forecasting recidivism, (b) in determining, at the outset, which children will probably become delinquent unless timely intervention diverts the predicted course, and (c) in suggesting fruitful lines of research into the causes of recidivism.

He answered (to the satisfaction, he believes, of most participants in Section IV) the main objections to the use of prediction tables: (a) that they assume a deterministic, even fatalistic, sequence of cause and effect in human affairs and leave no room for "free will"; (b) that they allegedly fail to take account of changing personal and social conditions because built on the assumption that the traits and background factors as they entered into the table originally will remain constant; (c) that they employ only a small fraction of the numerous and complex influences involved in human conduct and do so as separate items rather than by way of a unitary dynamic syndrome; (d) that they cannot truly "indi-

vidualize," since they deal with a person as a statistical type.⁶⁴

Under the topic of Improvement of Predictive Devices, the General Reporter discussed (a) improvement of the raw materials entering into predictive tables and of check-ups on the relationship of the predictive factors to outcomes; (b) improvement of statistical techniques; and (c) validation of experience tables.

(a) The General Reporter pointed out that many of the contributors to the symposium emphasized the need of building prediction devices on sound raw materials. "All the neat tables and sophisticated mathematical statistics in the world cannot transform unverified raw data regarding temperament, character, and sociocultural conditions into trustworthy information. This applies also to the reliability of the check-up on recidivism."⁶⁵ In the experience of the writer and his co-worker, Dr. Eleanor T. Glueck, official records are commonly not sufficiently comprehensive and reliable to be the basis of predictive techniques.

(b) After pointing out that control groups are necessary, the General Reporter adverted to the sophisticated mathematical techniques which in recent years have characterized work in the prediction field (especially the work of Ohlin and Wilkins), in respect to such problems as the relative accuracy of different syndromes of factors as indices of the total set of forces affecting behavior on parole; degree of "predictive efficiency" (*i.e.*, the extent to which a predictive device improves forecasts over choices based simply on knowledge of an over-all actual rate of recidivism); improvement of the prognoses of the behavior of the "unpredictable" (*i.e.*, cases with an equal chance of success or failure under the factors first used); maintenance of "predictive stability" of tables when they are applied at successive periods; "overlap" of factors; and guidance of the selection of predictive factors in accordance with some preëxisting theory of criminal causation or recidivism. The Reporter expressed the view that while all these mathematical refinements are not to be discouraged and are indeed indications that prediction technique is

⁶⁴ For the answers to these criticisms, see Glueck, S., *op. cit.*, pp. 16-17.

⁶⁵ *Ibid.*, p. 19.

entering the hallowed halls of Science, they are not as important as is the basic work and may not be necessary in constructing a useful prediction device. "In this matter what will determine the issue is not so much mathematical theorizing as the pragmatic test expressed in the proverb that 'the proof of the pudding is in the eating.'"⁶⁶

(c) Validation of "experience tables" was emphasized as the last step in determining their usefulness and reliability. Several validations of the Glueck Social Prediction table were mentioned.

Unlike the other General Reports, the one by the writer ended with certain Resolutions to be presented to the Congress. After lively discussion, the section adopted these Resolutions, with minor modifications; and upon their presentation to the Congress at the plenary session, they were adopted by a vote of 260 to 10:

"1. That fundamental attention should be paid by legislators, judges, correctional officials, clinicians, and researchers in criminology to the problem of recidivism as a major issue in the prevention of crime and the treatment of offenders. In order to achieve these purposes it is recommended that adequate prognostic services should be established in the various countries.

2. That the prognosis of recidivism can be improved, among other methods, with the aid of prediction tables based on a demonstrated high relationship between certain personality, character, biological, and socio-cultural factors on the one hand, and varieties of conduct on the other.

3. That the use of systematic methods of prognosis, including validated predictive devices, should be encouraged; provided that such methods are not applied automatically, but used as instruments in the hands of teams composed of professional skilled workers serving agencies charged with the administration of justice involving juvenile and adult offenders.

4. That, because of the close relationship between recidivism and early delinquency (*Frühkriminalität*), it is advisable to encourage the development and use of prognostic devices, including predictive tables, in the prediction of early delinquency.

5. That the utmost care needs to be taken in the definition, assembling, and verification of the factors which form the basic data on which prognostic methods, including prediction tables, are built, and in checking up on the actual extent of recidivism as related to such factors.

6. That an indispensable aspect of any improved prognostic technique is the validation of the predictive methods on samples of cases other than those on which they were developed, in order to transform them as far as possible into effective instruments for prognosis."⁶⁷

⁶⁶ *Ibid.*, p. 22.

⁶⁷ *Memorandum of Conclusions, op. cit.*, pp. 5-6.

Discussion.—While, at the opening of the section meetings, it appeared that the views of Dr. Drapkin and the other General Reporter (the writer) were at opposite extremes, frank discussion, in which many participated, disclosed that Drapkin was not opposed to the employment of predictive devices provided they were soundly constructed, not used by amateurs, and employed not exclusively but as adjuncts to clinical and judicial practices. Such prerequisites were envisioned by the writer in his General Report.

All the General Reports and most of the individual reports were of high calibre; and it is doubtful whether the topic of recidivism has previously received such a thoroughgoing examination from various points of view. But the idea that there are methods of predicting recidivism which hold high promise seemed most to intrigue the members of the Congress. And well it might; for the approach to criminologic and penologic problems through the avenue of the prediction table has value not merely as an aid to improved administration of justice but also as a rational means of narrowing the field of inquiry in analysis of causation and in the structuring of case-histories. Some device is necessary to render criminologic research more pointed, less sprawling, less intoxicated by the heady wine of some single "theory" which, instead of guiding research, may bias and blind it; and the writer is convinced that the most direct road to these desiderata is the prediction table, which checks systematically on the results of organized and objectified experience and focuses attention on the operationally relevant.

XII

Mr. Charles Germain (France) and Dr. George K. Stürup (Denmark) were the reporters in Section V, on the *Treatment of Recidivism*. After considering the legislative and administrative problems involved, Mr. Germain^{67a} underscores the proposition previously emphasized in several sections that the control of recidivism, like the prevention of original misconduct, entails the utilization of exact knowledge of causes. Yet, he claims, even the best researches have thus far not produced a formula to express, with scientific rigor, the combina-

^{67a} Germain, C., *Le Traitement du Récidivisme, Rapport Général, Section V, Troisième Congrès International de Criminologie, Londres, 12-18 Septembre 1955.*

tion of elements which bring about the criminalistic reaction, since many factors found in the careers of delinquents exist also in those of the law-abiding.

Like other Reporters, Mr. Germain points out that the aims and methods for preventing recidivism do not differ essentially from those applicable to control of first offenders, since, apart from chance delinquents who are not likely to recidivate anyhow, the factors leading to recidivism are in large measure the ones involved in the original delinquency. Nevertheless, a basic cause of recidivism is the ineffectiveness of treatment, either at the origin of delinquency or during the first peno-correctional efforts. Germain deplores the sharp differentiation between the treatment of juvenile delinquents and the treatment of adult offenders, since there is a continuity in the evolution of criminal tendency in a person. Inadequate employment of probation, and especially improper execution of the first sentence of imprisonment, far from failing to counteract a criminalistic tendency, may even enhance it. Imprisonment should be avoided where other measures are more promising. The giving of short-term sentences should be limited. Longer sentences should be designed, on the one hand, to omit useless rigors (which can only aggravate an antisocial sentiment on the part of the prisoner) as well as influences which lead to social maladaptation and render rehabilitation more difficult, and, on the other hand, to provide reeducative influences adapted to the needs of the individual and planned to bring about his progressive readaptation to society. It is also indispensable to provide post-penal assistance and gradually to restore the ex-prisoner's civil rights. In the case of habitual offenders, a period of relatively indeterminate duration is required, to be applied by judicial authority after a thorough criminologic study which should continue both during incarceration and thereafter.

Dr. Stürup⁶⁸ reserves the term "professional treatment" for that of a specialized character "with stronger emphasis in some cases on psychological structure; in other cases on the more directly educational procedure." But for all cases an "emotional contact" with one or more persons is basic,

⁶⁸ Stürup, G. K., *Treatment of Recidivism*, General Report, Section V, Third International Congress of Criminology, London, 12th to 18th September, 1955.

"in order to normalize the recidivist's group membership and in order to give him a true picture of his status in relation to the norms of the society."

Preliminary evaluation of the total situation is needed as a basis of diagnosis, which must be kept fluid. Both analysis and synthesis of personal and background data involve, admittedly, "a more or less intuitive" act. Since factors are not stable, the therapist must be elastic, "and not once but over and over again must attempt to place the criminal in situations affording possibilities for better adjustment and giving better opportunities for avoidance of later maladjustments."

"Planned treatment" should realistically take into account the fact that the measures adopted must usually be carried out not only by the professionals but also by the security and workshop staffs, and that some members of these groups have no full view of the consequences of their actions and may even vent their aggressions on inmates with intent to destroy rehabilitative efforts. Stürup points out that "a therapeutic climate may in itself act as a general strengthening of personal resources and thus be an important aid in the healing power of nature" in reducing the ill consequences of personal conflicts, including aggressiveness.

Discussing environmental maladjustments, Stürup makes a telling distinction between the sociologist's general environmental influences, which are only potentials to certain individuals, and the actual environmental experiences.

"It is a fact that a man is rewarded and punished by the sort of reputation he has, and especially by the reputation he thinks he has. This means that serving a sentence—forcing upon the man a 'bad reputation'—can mean a greater risk for new crimes as well as greater risk for detection. We may add that the psychology of learning reveals that punishment is no effective remedy for unlearning a type of behavior. On the other hand, we see the opposite effect of the reputation as it is experienced by the criminal himself when after some years it is proved to him that it was possible to come through several of the difficulties that in earlier life were followed by criminal reactions. After such a period, he feels relieved of a very heavy burden, and it is much easier for him to continue a life as a normal citizen."⁶⁹

On the problem of classification, Stürup warns against the possible ill effects of too homogeneous a grouping of prisoners (e.g., as "untreatables," which may result in "identification

⁶⁹ *Ibid.*, p. 5.

with the other 'hopeless' and stimulate the devaluation of the personality and outward aggressiveness"). To minimize the risk of antisocial contamination, groups should be small enough to permit the officer in charge to maintain personal contact with each inmate, thereby counteracting "unsuitable group-building." Before parole, prisoners should be permitted to work or to attend an apprentice school outside the institution, returning at night. "It helps the prisoner to obtain a feeling of security to know that he really is able to manage normal work, together with free people, and helps to prepare free people to see that 'prisoners are also people.'"

The psychiatrist is indispensable to the treatment task, but he must work with a team. For the more seriously maladjusted, a more psychiatrically oriented treatment is necessary, the same staff operating both during the offender's institutional stay and during parole. Collaboration with the prisoner's family in the treatment program is of the utmost necessity. Stürup emphasizes the prime importance of means to counteract the ex-prisoner's "emotional loneliness" on parole and to contrive ways of giving the satisfaction that comes from "belonging." To prepare the prisoner to meet the economic, social, and personal problems facing him on release, he recommends "group-work of a more advisory character, directed by a senior staff-member in collaboration with the social worker who is going to take charge in the parole period."

Diagnosis, Dr. Stürup pointed out, should provide a plan of action, taking into account not only the individual's endowment, needs, and wants but "what part of these things that are going to be of importance to behavior can be expected in a given environment."

In a valuable analysis of the general and special problems of treatment, Stürup emphasizes that:

"The initial examination should define the possible therapeutic situation. Does the new inmate already realize a need for another solution to his problems? Has he an obvious satisfaction through his criminal deeds (special sexual needs, special forms of aggression, etc.)? Will he be willing to accept difficulties during the period of treatment? What is needed in order to make him accept such troubles? How can his own collaboration be secured?" 70

⁷⁰ *Ibid.*, p. 8.

Stürup points out that the prisoner conceives even the examination by professionals as directed against him, since it is part of the prison regime; and he speaks penetratingly of the psychology of treatment:

"When in spite of this a positive rapport is established, and the employee is identified with a friendly person, it will help to give the inmate a matter-of-fact attitude toward authorities. He will see that some authorities are able to smile, to understand a joke, and perhaps what is most important, be able to accept the possibility of making mistakes themselves. The process then taking place can in many cases be described as some sort of neurotization. Insecurity and sometimes a conscious anxiety can be found behind the expressed need for help. When a transference is established, it is important to carry it over to someone else. At the time of parole, such transference should include the social worker in charge of the case. . . .

"The value of the treatment for the individual himself should be especially considered. The neurotic may eventually feel relieved, the criminal will often, when treatment succeeds, be more neurotic than before and consequently more insecure. Sometimes after parole, he says that he does not like the new way of life, and it will often take a long time for him to be able to obtain personal gains out of this change. If the outward aggression is changed to an inward aggression, perhaps with suicidal problems, the personal value of such a result may be difficult to accept. If without this change, the public danger had been great, it may still, from a social point of view, be wanted. In such cases, the prisoner himself may think this new state better than the former with its risk of new crimes, new despair, and new imprisonment." ⁷¹

The therapeutic process should help the prisoner to render more realistic the level of his aspirations; he must be aided to obtain self-knowledge and a better "emotional balance."

As to ordinary medical treatment, Stürup makes, among other interesting suggestions, the observation that "some of the more explosive prisoners may, through periodic hormonal treatment, be helped to endure forced celibacy. When carefully controlled, this treatment seems a very safe procedure and can give such a prisoner sufficient self-reliance so that he can more easily accept his special problems." Stürup is also in favor of castration in cases "where indicated," and "after intensive psychiatric preparation, and together with ordinary rehabilitative efforts." He believes it gives a "man a fair possibility to resist abnormal impulses which he, before the operation, could not resist." He recommends follow-up clinics to aid ex-prisoners in need of psychiatric or general medical advice.

⁷¹ *Ibid.*, pp. 8-9, 13-14.

He suggests that prediction tables could be an aid in the development of the individual treatment program. "At the time for parole and the time for final discharge, new tables could help to demonstrate the alterations obtained."

The *Conclusions* of Section V may be summarized as follows: The subjects of prevention, legal aspects and penal aspects were discussed.⁷² As to prevention, recidivism has many causes. Social conditions should be improved, particularly the "less glamorization of the criminal in the press." As to legal aspects, such devices as the indeterminate sentence or measures of security are "essential on a sufficient basis of law to insure adequate treatment of the recidivist."⁷³ Mechanical increase of length or severity of sentence upon recidivists is not recommended; the judge's choice in sentencing should not be too limited. As to treatment, while work, vocational training, and general education are useful, they are not sufficient and should be viewed as only part of a "general plan directed towards the reclamation of the individual" to be achieved through greater staff collaboration. Gaps in knowledge of treatment are (a) absence of long-term study of the offender, for the remedy of which it was proposed that "an international group should be formed to exchange case-histories," and (b) the need to create "suitable classifications in view of the nature of institutional treatment."

As to the role of professional treatment, (a) it is more necessary for treatment purposes to know "the prisoner's personality pattern, his estimation of himself, his educational background and social possibilities and type of criminal behavior, than his formal conviction";⁷⁴ (b) all members of the treatment team, including custodial officers, must be trained to understand the general plan of treatment and the importance of accurate, detailed observation; (c) for continuity of treatment, the prison staff must have a clear idea of the conditions under which the offender will live and the after-care officer should be part of the team; (d) to counteract the prisoner's feeling of loneliness and sense that nobody respects him as a human being, the offender should be included "in groups with professional and security staff," after care-

⁷² *Memorandum of Conclusions*, p. 6.

⁷³ *Ibid.*

⁷⁴ *Ibid.*, p. 7.

ful preparation for such treatment; (e) the section discussed "the value and application of specialized medical and surgical methods of treatment, in particular lobotomy, castration and, especially for paranoids, the use of new drugs."⁷⁵

Discussion—Germain's recommendations on treatment are in line with an increasingly widespread recognition that society is only cutting off its nose to spite its face by using imprisonment to vent its anger on an offending member; and that the wise policy, from the point of view of the soundest social protection, is to employ its institutions as human repair stations, where personality and character damage can be determined and remedied if possible.

Germain's familiar argument that little is known about causation of delinquency because many factors found among delinquents are also found among non-delinquents is a theme which, as some of the prior comments have suggested, has recently been greatly overplayed. There are likewise numerous factors among seriously ill persons that are also found among the well; yet it is possible to make a successful diagnosis and prognosis of many illnesses even with imperfect knowledge. There has been altogether too much seemingly profound but essentially superficial writing on the theme (derived from the physical sciences) that one must never use the term "cause," but only such evasive terms as "associated factor" or "decision theory." But the issue is a pragmatic, not a semantic, one. Where a considerable number of factors that make sense from the point of view of common and clinical experience are found to characterize delinquents far more than non-delinquents (the difference not being due to chance), it is highly probable that what is involved is a causal *connection* between such factors and misconduct (or recidivism) rather than an accidental *coincidence* between them; that, in other words, the delinquency (or recidivism) not only follows the traits and conditions that precede it but follows *from* them. That such a conception of causation is sound from a practical point of view is provable by (a) the fact that the concatenation of differentiative traits and factors

⁷⁵ *Ibid.* See, for example, "Sub-Coma Therapy in the Treatment of Homosexual Panic States," by R. H. Diverstein and B. G. Glueck, Jr., and Bromberg, W., "Sex Deviation and Therapy," *Journal of Social Therapy*, Vol. I, No. 4 (Oct., 1955), pp. 182-186, 203-210.

yields high predictive power when applied to a variety of samples of cases; and (b) that when such patterns of differentiative traits and factors are eliminated from a situation, delinquency (or recidivism) usually does not result. The fact that someday variations in people's behavior may be explainable in the more ultimate terms of differences in, say, endocrine gland function, or of microscopic physico-chemical reactions does not in the meantime prevent effective action on the basis of the existing cruder assessments of reality, any more than the recent development of nuclear science prevented effective coping with many problems of nature through employment of pre-nuclear chemistry and physics.⁷⁶ In the meantime, it can serve no useful purpose for workers in criminology and penology to keep wringing their hands about the inadequacies of the etiologic researches thus far produced. Medicine made therapeutic strides in several fields long before the specific causal agents in certain diseases were discovered.⁷⁷ It behooves us to work with the findings we possess until further development of the biosocial disciplines can produce better ones.

The importance of Dr. Stürup's contribution lies in his penetrating definition of the role of therapy in both institutional and post-institutional settings. The prison psychiatrist is shown to be much more than an affixer of labels, such as "not insane," "psychopathic personality," etc. Unless the psychiatrist is ready and willing to undertake various forms of therapy he serves no really useful purpose in the correctional institution but only creates an exaggerated impression of the impotency of his profession in coping with complex problems of personality, character, and conduct. Dr. Stürup's report is also valuable in stressing the need of a mental hygiene point of view on the part of all who deal with the prisoner; not merely the psychiatrist and social worker but also the guards, shop foremen, and others. Finally, he is on solid ground also when he conceives of the therapeutic process as involving thorough diagnosis and re-assessments, on the one hand, and an extension of the supportive and interpretive

⁷⁶ For a commonsense analysis of causation in criminology, see Glueck, S. and E. T., *Delinquents in the Making*, New York, Harper and Bros., 1952, pp. 164-171.

⁷⁷ See Glueck, S. and E. T. (editors), *Preventing Crime*, New York, McGraw-Hill Book Co., 1936, p. 4.

assistance to the ex-prisoner in the community, on the other. It is probable, however, that most American criminologists would not accede to his views regarding the desirability of castration.

The *Conclusions* of Section V are not new or startling. It is good that they emphasize the need of recognizing that the entire staff—custodial as well as professional—are involved in both the institutional and post-institutional therapeutic process; and that they all need training in analyzing treatment plans and making, as it were, proper “bedside notes.” That more attention should be paid to therapy in a truly fundamental sense is a conclusion that deserves more attention in the observance than in the breach. The use of psychiatrically indicated drugs, if not the more drastic surgical methods of lobotomy and castration, is something that, under proper guidance, might perhaps improve the life and labor of prisoners. As to gaps in knowledge, that there is need for the long-term study of offenders cannot be denied; but reliable American follow-up studies have already taught us much about the operation of Father Time and Mother Nature in the correctional process and about the great promise of prediction methods in both the sentencing and paroling procedures.⁷⁸

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The foregoing panorama of ideas, suggestions, and recommendations presented at the two Congresses, long as it is, is of course not as comprehensive as it might be; and because its construction involves the subjective process of selection of a sample of data from each of the numerous reports and other documents involved, it is unavoidably tainted with certain biases. Conceding these blemishes, the foregoing pages

⁷⁸ See Glueck, S. and E. T. *600 Criminal Careers*, 1930, New York, Knopf, 1930; *One Thousand Juvenile Delinquents*, Cambridge, Harvard University Press, 1934; *Five Hundred Delinquent Women*, New York, Knopf, 1934; *Preventing Crime* (editors), New York, McGraw-Hill Book Co., 1936; *Later Criminal Careers*, New York, Commonwealth Fund, 1937; *Juvenile Delinquents Grown Up*, New York, Commonwealth Fund, 1940; *Criminal Careers in Retrospect*, New York, Commonwealth Fund, 1943; *After-Conduct of Discharged Offenders*, New York and London, Macmillan Co., 1945; *Unraveling Juvenile Delinquency*, New York, Commonwealth Fund, 1950; *Delinquents in the Making*, New York, Harper and Bros., 1952; *Physique and Delinquency*, New York, Harper and Bros., 1956.

nevertheless show a lively awareness on the part of scholars, researchers, and administrators of the most complex issues involved in coping effectively with crime and recidivism. The views expressed by the various contributors afford food for thought to correctional workers in both the more simply organized societies and in those most thoroughly entangled in industrial, economic, and cultural complexity.

There emerges from it all a feeling that the free world is moving away from the old reliance on force and repression and pain infliction as "cures" for crime to an attitude compounded of humanitarianism and a reliance on scientific method. It is being recognized far and wide that to prevent children from failures of adaptation that lead to delinquency, to prevent juvenile delinquents from becoming adult offenders, to prevent adult criminals from becoming chronic recidivists will take more than the ancient incantations of legal formulas and the multiplication of ever harsher punishments and more maximal "maximum security" fortresses. It will take patience, understanding, and dedication—commodities all too scarce in the management of human affairs. In the meantime, the friendly exchange of ideas by representatives of many nations is all to the good.

COMMENTS ON "A PROGRAM IN SCHOOL PSYCHOLOGY"

IT is unfortunate that in his excellent formulation of a school psychology program recently, Paul Frisch¹ ignored one of the most vital and productive contributions the psychologist can offer.

Dr. Frisch recognizes that prevention of emotional disturbance is "the most important function of the school psychologist." He then suggests, for the psychologist, a program of "activity in curriculum development" and various educational activities with teachers and parents, based on such factors as "his awareness of the emotional impact of various kinds of learning experience on individual pupils." Frequently, however, we as psychologists do not know the answers to questions in this area. Knowledge gained from study of the abnormal cannot always be applied directly to the classroom.

The well-trained psychologist possesses, among his many skills, an excellent orientation in research methodology, which should be utilized in the school setting to help us learn more about educational process and its relationship to mental health. Any meaningful approach to prevention must center around a research program devised to answer the problems peculiar to a particular community as well as theoretical problems of a more general nature. This long-range program may be utilized simultaneously, in a more immediate sense, as an adjunct to in-service education, parent education, interdepartmental and interdisciplinary communication, and administrative consultation.

One final carping comment: This writer believes that, in presenting a specifically annotated hourly program for the psychologist's work day, Dr. Frisch has done disservice to a young and growing profession. Functioning in a truly professional capacity requires tremendous flexibility not only from school to school, but even from day to day in the same school. No "sample plan" can truly "illustrate the balance

¹ Frisch, Paul. "A Program in School Psychology," *MENTAL HYGIENE*, Vol. 40, No. 2, April 1956, pp. 258-266.

of activities of the school psychologist'' and there is always the danger that a schedule presented by one as a sample will be perceived by others as a prototype.

GILBERT M. TRACHTMAN

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Mr. Trachtman's suggestion that I should have avoided presenting a "sample plan" in fear of its being swallowed whole by school administrators is an evasive solution to an important problem, namely administrative responsibility for the nature and conduct of the school psychology program. If, however, a psychologist's functioning is inhibited simply by exposing administrative officers to a specific plan then this demand for blind conformity is an issue far more important than how the psychologist spends his time. I would doubt if our "young and growing" profession can solve this problem by side-stepping a description of a specific course of action.

PAUL FRISCH, PH.D.

BOOK REVIEWS

GERIATRIC NURSING. By Kathleen Newton, R.N., M.S. 2nd edition. St. Louis, C. V. Mosby Co., 1954. 424 p.

As in its first edition this book is divided into three sections, the first giving a general background and indicating the need for the nurse to have an awareness that the aged are no different from any age group except that "they have lived more years," and that many of the younger group will live to suffer similar disabilities. The necessity for the nurse to be aware that with proper care many of the disabilities of the aged can be minimized, that assistance and support can be given to members of the family which will enable them to retain the aged in their homes or in the community, and that there are facilities available in the community which can be used when required (*e.g.*, health visitors, occupational therapists, etc.). Attention is directed to the importance of working towards the rehabilitation of the patient from the time a diseased condition is discovered; it is this approach which is of a practical and understanding nature which could do much to develop the right attitude in the nurse towards the special problems of the aged.

The basic needs of the aged are described in the chapters on "basic socio-psychologic needs," "employment and economic security," "housing in health and during illness" as "the need for somewhere to live, something to do, someone to care." These are clearly understood as they are fundamental needs at all ages and imply the common need for recognition as a unique personality.

Problems which have developed as a result of rapid industrialization, technological change, and changes in our social structure are clearly stated and should give the nurse caring for the aged an intelligent understanding of the factors which to some extent contribute to the illnesses found and complicate recovery and rehabilitation, and should stimulate interest in the general problem which is assuming greater importance as the proportion of aged in a community increases.

Part 2 of the book deals with non-specific subjects under "general hygiene" and "nutrition" and contains much information which is notable for its practicability and sound common sense (*e.g.*, advice regarding lighting, planning of bathrooms, use of ramps and rails). It is subject matter such as this which is found throughout the book, which makes it one to be recommended not only to nurses but to those responsible for the administration of homes and institutions for the aged.

Part 3 deals with the clinical nursing of conditions most common to the aged; in this section, as in the whole book, not only the physical but the emotional needs of the patient are considered.

This is a good book on geriatric nursing but it is, as well, an outstanding addition to nursing literature because it deals with the whole person, with his mental and physical needs, and with his needs as a member of his society. The interaction of the one with the other and the effect of this interaction in developing individual and community attitudes and in assisting in or complicating the rehabilitation of the aged is described with clarity and understanding.

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BEYOND THE GERM THEORY: The Roles of Deprivation and Stress in Health and Disease. Edited by Iago Galdston, M.D. Minneapolis, Health Education Council (A New York Academy of Medicine Book), 1954. 182 p.

In recent years one of the most salutary emphases in medicine has been that which pointed out the variety of forces that affect human beings. Doctor Galdston, both as author and editor, has been helpful in defining these concepts.

This present book, a compilation of several special articles, has carried this presentation one step further. The factors of stress, and deprivation as a form of stress, are brought into much clearer focus in this collection to emphasize the concept of how large a role these forces play in the production of human illness. The reader concerned with preventive concepts can begin to see some of the needs for application of this knowledge in the broad field of mental health.

Actually, the articles only pique one's curiosity as to further applications. Especially intriguing are those chapters which deal with animal experimentation. The reader is equally teased by the revelations from the field of anthropology. In the earlier chapters of the book the point is made that for centuries we had knowledge about deprivation as a cause for illness which was difficult for us to use. It may well be that our newer knowledge of emotional deprivation and similar stressful situations will continue to be a challenge for us in the preventive field.

One can only hope that other writers will continue to clarify and

integrate the kind of information that is available in this book. It is proposed, therefore, as a most readable source of provoking one's curiosity.

HENRY H. WORK

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THE CLINICAL INTERVIEW. Vol. I. By F. Deutsch and W. F. Murphy.
New York, International Universities Press, 1954. 613 p.

This book is the first of two volumes prepared for teaching residents in psychiatry, the aim being to improve their techniques of interviewing and psychotherapy. The book is comprised mainly of case studies of patients suffering from neuroses. Particular attention is given to a group of disorders commonly called psychosomatic, such as asthma, atopic dermatitis, colitis, arthritis, and others. Each chapter dealing with a syndrome follows the same pattern of presentation: first an introduction of the syndrome in general, then an abbreviated case presentation and preliminary discussion of that specific case, followed by a verbatim interview between psychiatrist and patient, and last a short final discussion and follow-up note and detailed bibliography.

An important section of the book appears before the case studies and consists of a thorough appraisal of ways of applying psychoanalytic concepts to resident training, particularly through the use of the interview. This chapter will be appreciated and found helpful to all professional persons concerned with interviewing where that traditional device of getting information is appreciated also as a therapeutic instrument. Social workers, psychologists, and non-psychiatric physicians will be interested in the authors' description of the associative anamnesis which Deutsch introduced into psychiatric residency training at St. Louis and which in this book becomes the model therapeutic interview.

This book brings much information and many insights about psychoanalytic theory and practice to professional persons who work in the field of human behavior. However, it is not a substitute for extensive and closely supervised clinical experience. Despite the good organization of the text and its high literary value, the contents must be read slowly and carefully, with plenty of time for thinking through and discussion with experienced psychiatrists who understand psychoanalytic theory and practice. Persons not trained in psychiatry or psychoanalysis should also be warned that the interview techniques of Deutsch and his colleagues cannot be applied completely and unchanged in every kind of interview situa-

tion, and that there are dangers if the inexperienced person attempts to use their approach literally and without adequate supervision.

In the opinion of the reviewer, this book merits a place in the libraries of medical schools and graduate schools of the social sciences as well as in every departmental library where persons come for reading about the interpersonal phenomenon known as a clinical interview.

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YOUR MARRIAGE. By Norman E. Himes. Revised and edited by Donald L. Taylor. New York, Rinehart & Company, 1955. 384 p.

Dr. Taylor's revision of the standard textbook of the late Norman E. Himes would generally be regarded as materially increasing its value. Primarily beaming his work at students and young people contemplating marriage, the editor-author nevertheless devotes the greater part of the book to discussing problems that develop subsequent to marriage.

In addition to editing the original edition, he has added new chapters on courtship, love, the best time to marry, the part personality plays, home management, prenatal problems, infant care, social factors, and divorce.

To try to evaluate the merits of this new edition in comparison with other works on the subject would be useless if not impossible. For one thing, to be quite fair one would have to read all of the thousand or more extant books and articles on marriage and family relations listed in Albert Ellis's recent bibliography—a superhuman task.

The material presented is largely elementary, as it should be considering the purposes of the book. The statements made and conclusions drawn appear to be the product of much modern thinking and considerable research. For example, in the new chapter on divorce, we read: "We are still operating under the illusion that if we make divorce expensive, painful, and difficult to obtain, we will stop families from being unhappy. This is like saying that if a man can't see a dentist, his tooth won't ache. We are also likely to interpret divorce as a threat to the institution of marriage. Actually, many people who seek divorce are seeking relief from a particular marriage only. They are not against marriage as such; they look forward to making a happier marriage. They have no intention of destroying the institution itself. Instead of trying to keep people who want divorces from achieving their goal, we should

try to figure out how we can keep people from wanting divorces" (p. 319).

More than an academic understanding of the facts of life is displayed in the author's comments on families and courts: "The philosophy of our courts centers around the probability of guilt and the branding of criminals. Each trial becomes a contest between two lawyers in displaying their skill and their ability to free or convict. Often, the accused or aggrieved is forgotten in the struggle. There is little attempt to determine the cause of the behavior and to apply the necessary treatment. In other words, the sanctity of the home or the family as a unit receives little consideration in the courtroom. If a family comes to court, it must be prepared to 'do battle' rather than seek reconciliation and understanding" (p. 315).

Also: "In order to get a divorce, many people have to give false reasons for wanting it. Our legal records are full of false and meaningless reasons why people seek divorce. * * * All of this points to the stupidity of our present divorce laws and the need for drastic revision" (p. 322).

The emotional costs resulting from family failure ending in divorce are touched upon. Among those mentioned are regret, feelings of guilt, blame, loneliness, the attitude of friends, effects upon children, readjustment of sex habits.

The final chapter is devoted to the need for marriage counseling. For those contemplating marriage and those having difficulties in marriage, the thought is expressed that to postpone a conference with a counselor is as foolish as waiting to see the dentist until the tooth needs to be pulled. Particularly for divorced persons contemplating remarriage, it is urged that they should seek the advice of counselors and psychiatrists before making a final decision.

Some of the reasons people needing this type of help are sometimes so reluctant to seek it are fear of being seen in the counselor's or doctor's office; the notion that some kind of a stigma attaches to such service; fear that to consult will be an admission of failure; inability of the patient to understand what his problem is; fear that he won't be able to state his case; fear of being a "guinea pig" or a "case"; fear that he will reveal things he never meant to confess; and, sometimes legitimately, lack of faith in the counselor or psychiatrist.

For the mental hygienist or the orthogamist the book seems to contain nothing particularly new. But it does tend to orient the layman in the direction of these professions.

PAUL W. ALEXANDER

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AMERICA'S ROLE IN INTERNATIONAL SOCIAL WELFARE. By Alva Myrdal, Arthur J. Altmeyer, and Dean Rusk. New York, Columbia University Press, 1955. 109 p.

These lectures were originally given during the second series of Florina Lasker Lectures at the New York School of Social Work in 1953. Each deals with a different aspect of the United States' involvement in international social welfare.

Our concern for the welfare of people throughout the world and the responsibility we have accepted for the amelioration of their economic and social conditions have become essential elements of our foreign policy. The United States, working both through unilateral agreements and the United Nations, has initiated large-scale programs of economic aid, provided technical assistance, and trained a considerable number of personnel. In spite of these efforts, Dr. Myrdal points out in her paper, "A Scientific Approach to Social Welfare," we appear to be waging a losing battle. Increased productivity has failed to keep pace with the increase of population and the social level has improved little, if at all. Dr. Myrdal raises several questions that call for scientific study and appraisal. Have the efforts undertaken been directed too much toward increasing economic productivity with too little attention given to social welfare gains? Have efforts toward social welfare been too "spotty," with too little integrated national planning? Are we approaching the problem scientifically, and have the underdeveloped countries the "techniques for planning"? These are serious questions.

It has become essential for us to study the extent to which technical social welfare skills are exportable or importable. There is danger that we may be attempting to impose our social values on others or to equate "poverty" with "underdevelopment." Dr. Myrdal urges study of the extent to which countries are achieving "balanced development" and "community development." By the former she means closely related economic and social planning; the latter embraces the concept of the democratic participation of people in their own change. This must take place from the bottom up with a minimum of outside assistance if they are to follow their own preferences. This is, of course, a familiar and basic concept of American social work.

What contribution may the United States be expected to make to international social welfare? Dr. Myrdal suggests that this is difficult to answer because our level of economic and social development is so high that few countries can benefit from our highly specialized skills or from the social welfare measures that meet our needs. Our greatest contribution may be a social science, that is, the obser-

vation of social facts and the analyses of social relationships that we excel in making. It is her belief that the sound development of international social welfare rests upon basic research—"a complete cultural anthropology, a theoretical science of social change, and a comparative one of social welfare policy."

Mr. Altmeyer, in "Training for International Responsibilities," expresses the view that the basic principles and methods of American social work have universal applicability because all people have common human needs and motivations. He discusses some special problems related to our current training and consultative responsibilities. Mr. Altmeyer reminds us that students and visitors from other countries are contributing to us, particularly by stimulating us to re-examine our methods and by making us aware that social forces exert an important influence.

In his paper, "Peace, Freedom, and Social Welfare," Mr. Rusk discusses the relationship of action in the field of international social welfare to broad political problems. He describes some of the social activities of the United Nations and its specialized agencies. Important by-products of our participation in technical assistance programs are that we are learning to understand people in different parts of the world and by our cooperative social action are helping to build a strong world community on the side of democracy.

While these papers are not specifically concerned with the field of mental health, the concepts expressed and the questions raised are important for us to consider seriously. "Good mental health" tends to become a social value—an absolute goal. We may run the risk of superimposing our mental health values on people in other social milieus. It is well for us to take stock, as the field of international social welfare is beginning to do, of those of our beliefs and standards which are exportable and those which are not, of those which are common to everyone and those which each group must develop for itself on the basis of its own cultural, social, and religious values.

HELEN SPEYER

New York City

STUDIES IN THE SOCIAL SERVICES. By Sheila Ferguson and Hilde Fitzgerald. London, Her Majesty's Stationery Office and Longmans, Green, 1954. 367 p.

Intended to "discuss the family and the efforts of public policy to help it bear the strains of war," this thoroughly documented report is in the United Kingdom Civil Series on the History of the Second World War. The book contains the results of welfare re-

search initially projected by R. M. Titmuss, the origins of which were reported in his *Problems of Social Policy*, the predecessor in this series to the Ferguson and Fitzgerald volume.

Admittedly, *Studies in the Social Services* is not a complete review of all the governmental and voluntary services developed and extended to meet Britain's family problems during the trying years of World War II. Studies, for example, on delinquency and divorce had to be omitted. Instead, we find a comprehensive discussion of certain social welfare and health programs designed to meet primarily the complex wartime relocation problems of mothers and children. It must be remembered that separations in England involved not only men conscripted into the armed services but also women, both male and female civilian workers, and evacuees, especially children, and that these relocations were typically "reverse migrations," from the cities into towns and villages initially ill-prepared to offer the services needed by the newcomers.

The book opens with a consideration of "the growth of government action" against the "ups and downs of the family." Making effective use, here as elsewhere, of census and other official governmental data, the authors point out how the smaller families of modern times provided fewer close relatives to whom one could turn in emergencies. Many factors brought about the reorganization and sometimes the disintegration of community life—e.g., the fact that "two houses in every seven were affected in some way by enemy action." Limited family and peacetime community resources could not then take over, in the face, simultaneously, of the mobilization of women and rises in the birth rates of both legitimate and illegitimate children. To all of this were added shortages in crucial consumer goods. Appropriate government offices had to step in and make policy decisions, sometimes affecting intimate aspects of life which could never in England, except in such times of crisis, have become subjects for government consideration.

Among the results, after transitional periods in which much personal suffering occurred, was an outcropping of what the British call "schemes"—a national milk scheme, schemes for emergency maternity services, schemes for unmarried mothers, a bombed and sick babies scheme, a tuberculosis allowances scheme. The genesis of each of these, sometimes involving private and government agency partnerships, is described fully.

The origins and developmental experiences of wartime day care and residential nurseries and extensions in health services for children are thoroughly reviewed. Chapters on tuberculosis and the family and on the shortages in nursing personnel are appended.

The effects on postwar services are exemplified by what happened in the area of illegitimacy:

"It was one of the social consequences of the war that the government accepted new responsibilities for the welfare of unmarried mothers and their babies . . . the position of the unmarried mother in society changed beyond recognition. Over a wide area of needs, charity and poor law relief were replaced by defined social benefits." (pp. 138, 140)

This report, like others on the war years, provides evidence to support a curious proposition about our times: "that the war should prove an agent of great social advance." More than this, the report vividly demonstrates how the morale of a people, especially in times of stress, is dependent upon properly timed societal action and appropriate health and welfare supports.

Obviously built upon a sizable amount of scholarly work, the studies in this book should become a useful resource for our understanding of an important phase in the development of British family and child welfare services.

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MOTHER-DAUGHTER RELATIONSHIPS AND SOCIAL BEHAVIOR. By Rose Cooper Thomas, A.B., M.S. Washington, D. C., Catholic University of America Press, 1955. 365 p.

This study, which was undertaken as a Ph.D. thesis in psychiatric social work, is an important contribution to the literature of this field and to research in the significance of mother-child relationships in the etiology of schizophrenia. The author refers to it as "an exploratory investigation of the correlates of mother-daughter relationships and social participation of a group of patients with schizophrenic reaction," which was "designed to test several unverified hypotheses in current socio-psychological literature on mother-daughter relationships and mental illness."

The study group included all Negro women patients admitted to St. Elizabeth's Hospital, Washington, D. C., over a three-year period who were residents of the District, between the ages of eighteen and thirty years, diagnosed as schizophrenic reaction, reared in the home of their mothers, and with a sister who had not developed mental illness at the time of the study. The medium used was the interview, and the unique feature of the research is the study of the non-psychotic sister as a control group—"a method not previously reported in the literature." There were eighteen patients who met the requirements, four of whom were sisters from a family of seven-

teen siblings. Besides the study of hospital and social agency records of the patient and her relatives, from two to five interviews were held with each respondent—the patient (except those seriously disturbed), her mother, her sister, and sometimes other relatives. In all, there were fifty-one subjects whose patterns of mother-daughter relationships were placed under scrutiny.

Without exception the patients were unwanted children, and one significant finding of the study was the mothers' verbalization of feelings of rejection in the research interviews. Other problems which appeared throughout the group were the dual parental role of the mother who functioned also as provider, differential treatment of siblings by the mother, maternal attitudes which hindered normal growing-up process of the patient, serious marital difficulties of the parents, the absence of the father or his failure to assume responsibility, inadequate material goods, and insecurity of the patient with the mother expressed most often in silent submissiveness or silent rebellion.

The case material is analyzed at length on the basis of three major hypotheses: (1) that the mother of the patient with a schizophrenic reaction has restricted the social participation of her daughter; (2) that the psychotic daughter has responded submissively and the non-psychotic sister less submissively to the maternal restriction of social participation, and (3) that the mother repeats the pattern of relationships which she had with her own mother. Differences in the two groups were also studied from the point of view of health, ability, and interest in people; father-daughter and sibling relationships, and situational factors affecting adjustment.

The evidence in the cases substantiates the author's hypotheses, and she concludes that maternal restriction is correlated with lessened social participation and that less or no restriction is correlated with social participation. A dependent type of mother-daughter relationship lacking in warmth and understanding and based upon unquestioning obedience of the daughter not only hinders social participation but may be taken as a poor prognostic sign for adequate social adjustment in later life. Factors associated with submissive behavior of the patient were found to have been poor physical health and low vitality, other negative physical characteristics, negative qualities associated with similar traits of either parent, and poor adjustments in school, work, and marriage. The social participations of the daughter are most markedly influenced by maternal restriction in cases where the daughter lacks sufficient ego strengths to withstand or counteract maternal restriction or to engage in ego-involved activities. Internalization of the outer restriction may lead to constriction of personality development, a direct expression of which is submissive

behavior. The daughter who behaves submissively is less likely to become a social participant, while the daughter who behaves less submissively or is non-submissive is more likely to become a social participant. The social participation of the non-psychotic sister was found to be associated with good health, greater ability and physical attractiveness, and ego strengths which facilitated the development of the relationship with the mother and other interpersonal relationships.

The study is conscientious, meticulous, and scholarly. The author points out its limitations, emphasizing that because of the small number of cases and other factors the findings are suggestive rather than conclusive. They are consistent, however, with conclusions from other research regarding the influence of mother-child relationships especially in the development of schizophrenia, validate the interview as a research technique, and point the way to additional studies along similar lines, particularly the use of siblings as a control group.

The book should prove useful not only for other research but for teaching in social work, psychiatry, and related fields. The first chapter describing interview techniques and revealing the author's skill, warmth, and understanding should be of special value, as well as the sample cases presented in detail. The chapter dealing with basic concepts related to the study includes a helpful review of literature. The book is not easy reading, however. The case material is broken down and analyzed by charts and dissertation in accordance with the author's hypotheses and is effective in supporting these. The result is dull and repetitious in contrast to those sections of the book where the author is freer and writes with interest, perception, an excellent command of language, and a sense of humor, making these sections pleasant reading. This reviewer would have found the case material easier to follow if at the beginning of the book a brief summary of each case had been presented.

The author wisely limits her focus, which she never loses sight of, to material within the competence of the social worker. Psychiatric and psychological findings are omitted, which this reviewer considers regrettable. The study satisfies the requirement for a doctorate in social work, but how much more interesting and provocative it would be if the clinical study of the patients could be evaluated against the background of the author's rich material! Also, with the relationship the author was able to establish with the mothers and sisters, clinical studies of these respondents would certainly have been possible had the situation permitted. A comparison of Rorschachs on the patients, mothers, and sisters, for instance, would have made a

stimulating project for a psychologist. We talk much about the team approach in research, and this study is a good example of how much more research interest this contribution might have had had it been possible to undertake it on this basis. The author's work stands on its own merits, however, as an ably conceived and executed piece of work.

MARY C. SUMNER

BASIC CONCEPTS IN VOCATIONAL GUIDANCE. By Herbert Sanderson. New York, McGraw-Hill Book Company, 1954. xiii + 388 p.

Vocational guidance is not new. Its beginnings predated World War I and coincided with the development of tests of intelligence and aptitudes. The rapid professionalization of the field since then has been a product of a pervasive social demand arising from such seemingly strange bedfellows as a changing educational concept, an economic depression, a second war, the scientific industrial management movement, and just people—able-bodied and handicapped—in need of vocational help.

Undaunted by the gaps in scientific knowledge, guidance practitioners have written extensively mainly about techniques and how the energetic counselor could keep himself busy. While much is said about maintaining cumulative records and identifying aptitude tests of all sorts, there is surprisingly little to inform the counselor about *counseling*. In the light of these events, it is easy to understand that Sanderson should choose to press forward a theoretical discussion of *basic concepts* at this apparent late date. Implicit in the author's exposition is the thought that the field of counseling must employ the tools of research and sober reflection about human problems if it is to remain a professional discipline in psychology and not degenerate into the status of a technical skill.

Sanderson rejects that aspect of contemporary guidance practice which postulates that the counselor "knows best" what is good for the client. When the client resists, the counselor employs persuasive means calculated to enable the client to accept the counselor's viewpoint. Thus, the client who gives himself up to the will of the counselor is considered "cooperative." Conversely, the client who insists on his right to decide for himself may be labeled "recalcitrant." Neither term, he feels, has a place in a system of counseling which upholds the client's right of self-determination.

In the preface, Sanderson presents a "help-centered" approach, acknowledging his debt to "non-directive" counseling and "functional casework" and the contributions of Jessie Taft, Frederick H. Allen, Herbert Aptekar, and Carl Rogers. The first two chapters

("The Nature of Vocational Guidance" and "The Helping Professions") represent for the most part a clear and incisive exposition of "help-centered" counseling; they are chapters which can be read with profit by all guidance personnel.

Although the *content* of vocational guidance is the manner in which one earns a livelihood, the *focus* is the helping process which enables the counselee to effect appropriate changes within himself. In "help-centered" vocational guidance, the client gives direction to his own process of change, with the counselor taking responsibility for helping the client to realize this process. It differs from the "diagnostic" approach in which help is conceived as a "planned, goal-directed treatment . . . the treatment objectives and techniques are variably selected to meet the requirements of the diagnosis." It differs from "functional casework" in which the caseworker *initiates* the re-structuring of the relationship to overcome "problems arising out of destructive use of relationships." It differs from "non-directive" counseling in that it is not based on "permissiveness" but on a clearly structured client-counselor relationship, involving the client's right to accept or reject any part of the service. The counselor is active in assisting the client to express his doubts and negative feelings and to arrive at a decision for which he can assume some responsibility. And lastly, the client also learns to work with limits by discovering that he can weather the painful aspects of being helped.

As in psychotherapy, Sanderson enunciates that self-help does not arise spontaneously nor through an intellectual exchange, but is brought about as a result of a psychological interaction between client and counselor. People frequently have to be helped to help themselves.

Again, the author draws from the social work profession in stressing the importance of delineating the *focus* of the problem and the *function* of the counselor so that the entire relationship is kept on a reality level without allowing it to become an experience in total personality analysis.

Sanderson emphasizes the necessity for the rigorous training of the counselor so that he may be able to fulfill his responsibility in the client-counselor interaction. Just as the other helping professions provide supervised internships for their trainees, counselors too must grow professionally. "Growth is an experience which becomes meaningful only when the learner can internalize that which is happening around him. A personal involvement is essential in the growing process . . . standard classroom lectures and laboratory procedures do not contribute significantly to the intrinsic development of the student."

Some sense of the relationships of vocational guidance to psychiatry, clinical psychology, and social casework is explored and viewed from different angles. The author advocates the need for each discipline to understand each other's content and focus so that each may contribute to the resolution of the problem of a human being. He explores the significance of interdisciplinary cooperation in the settings of the "clinic team" and the "professional consultation."

In the second part of his exposition, Sanderson elaborates on the interaction dynamics of the counseling relationship from its inception to termination, and makes a special point of helping the counselor to turn the spotlight upon himself.

Chapter 8 will particularly appeal to agency administrators and supervisors for here is presented a discussion of how counselors should be trained. The stated objectives of training are drawn once more from the field of social service and, stated briefly, are (1) student growth and capacity for professional development, (2) capacity to work within the structure and function of the agency, (3) development of skills and knowledges, and (4) growth in ability to make use of supervision.

In the latter part of the book, the concepts are applied to counseling situations involving adolescents and their problems of dependency and parental relationships. The illustrative material is apt and lucid.

The present reviewer is currently witnessing a wholesale recruitment of vocational rehabilitation counselors by public and voluntary agencies. Sanderson's book would appear to be a primary source of basic information for the benefit of the university training programs in rehabilitation as well as the agency personnel charged with training the new counselors in their new duties. One wishes, however, that Sanderson had drawn his illustrative case material from the field of vocational rehabilitation, in which the majority of guidance counselors now find themselves. Counseling psychologists will also welcome this publication as germane to their field even though the author will tend to overlook occasionally the relationship between the concepts he espouses and the well-delineated principles to be found in psychological learning theory.

LEONARD W. ROCKOWER

THE DIRECTION OF HUMAN DEVELOPMENT, BIOLOGICAL AND SOCIAL BASES. By M. F. Ashley Montagu. New York, Harper and Bros., 1955. 404 p.

This is a stimulating and challenging volume. Readers who are familiar with Montagu's *On Being Human* will recognize this book as an expansion and enlargement of the author's conception of the

nature of the human being as essentially one that requires interaction with others. When the author examines the nature of the infant at birth both in terms of its organic and social aspects he finds that the child is born neither evil nor with an indifferent nature. He is so constituted that he responds to conditions characterized by the presence or absence of love or emotional security and insecurity. Love in the emotional security sense is essential to the development of a cooperative individual.

The child begins life in a process of interaction between parent and offspring and there is thus from the very beginning an essential dependence of one organism upon another. Organisms are essential to each other's development and the probability of survival of living things increases with the degree to which they adjust to their environment—which includes adjustment to each other. The author's review of the evolutionary process in both infra-human and human organisms leads him to conclude that the trend toward cooperative behavior is found throughout the animal kingdom and is more important than disorganization and competition.

Providing emotional security is essentially in man's hands through the types of environment, *i.e.*, experiences, which he provides for the growing child. A great variety of evidence is assembled to show that when the growing child is deprived of love extensive damage to physical as well as psychological development may result. Observations from Ribble, Goldfarb, Spitz, Beres and Obers, Holman, Bowlby, Levy, and many others are cited in support of this claim.

Further evidence for the importance of human stimulation is provided through a variety of studies of children reared in relative isolation as compared with those reared in understanding and accepting groups.

The evidence indicates to the author that from birth onward the direction of human drives is toward cooperation. If these drives are frustrated, the development of the organism is disrupted. If they are satisfied, social happiness and health results. This conclusion has extensive implications for the school, for the home, and for the community as a whole which are discussed in some detail.

It is a distinct contribution to have produced a study concerned with the positive aspects of human development as this one is. As Julian Huxley has pointed out, "Human life is a struggle—against frustration, ignorance . . . ; but it is also a struggle for something. . . ." Montagu's attempt has been to elucidate what it is that the "struggle is for." There has been much emphasis on aggression, frustration, conflict. We need more study of cooperation—its nature, its place, and its development.

However, assembly and use of studies on cooperation, as with in-

vestigations in any area, require critical analysis—the weighing of evidence which supports as well as evidence which does not support. It is at this point that this volume could be strengthened. For example, much use is made of work of Margaret Ribble. Some critical analyses of Ribble's work have been published, but these critical analyses are not included in this synthesis.

Montagu has made a distinct contribution by assembling the vast and rich array of studies on cooperation ranging all the way from studies of one-celled animals to human personalities in group action. It is to be hoped that the next step will be further critical analyses of these studies, the inclusion of negative as well as positive evidence. In this way we may approach ever closer to a reliable conception of the nature and direction of human development.

RALPH H. OJEMANN

University of Iowa

SOCIAL SERVICES IN THE SCHOOL. By Jean R. Pearman and Albert H. Burrows. Washington, Public Affairs Press, 1956. 218 p.

Both authors are professors at Northern Michigan College of Education, Marquette. The former is associate professor of sociology, economics, and social work, the latter head of the history and social science department. They have set themselves a difficult task—in a small volume to meet the need of a wide range of readers, professional and laymen. Not all the chapters, therefore, will be of equal interest or help to all readers. A number of chapters are of specific rather than general interest; for instance, the section on state laws, introducing the work on studies of salaries of school social workers will be of interest to school boards and administrators rather than of help to teachers or new visiting teachers.

The book includes a brief and adequate history of the fifty years in the development of school social work—a slow but steady growth. Naturally the authors did not have space for more than brief mention of a few of the early centers and their dates, but it seems unfortunate that the program in Rochester, N. Y., could not have been described. More recognition might well have been given to the Public Education Association of New York, which not only maintained demonstrations in New York schools for many years, but also sponsored the first three national conferences of visiting teachers in 1916, 1917, and 1919, and in 1920 published a study by the newly formed and then small National Association of Visiting Teachers. The Public Education Association of New York also from 1920 to 1930 carried out the Commonwealth Fund's demonstrations of visiting teacher work.

The book evidences a conscientious endeavor to gather material on

case work and other subjects related to school social work, as well as material on the development and practice of this new service in the school. The reader gets a clear and convincing idea of the complex problems referred to the case worker and of the school's need of an additional service, if it is to educate and help many children who now are not profiting by their school experiences and possibly are actually being harmed by them. It gives a picture of case work as a necessary adjunct or essential extension of the service of the class teacher in order that each child may be able to participate in class activities and make use of his school experience, and thus may be kept from developing unconstructive attitudes and unhealthy emotional patterns which later may lead to delinquency or mental breakdown.

As educators, the authors show wisdom and understanding of the importance of the school social worker's relation to the teachers and the school as a whole and of their acceptance of one another as partners in the enterprise of adjusting and educating troubled school children.

Chapters on "Helping the Troubled Child" and "Working with Administrators and Teachers" make clear the complexities in properly introducing the work and the necessity of the social worker's maintaining administrative relationships as well as active cooperation with the teachers. It is important that a school social worker early become familiar with the attitudes, traditions, pressures, and other factors of the school if she is to become a partner in the educational enterprise and not merely an adjunct or an "outsider." These chapters will give the newcomer a proper perspective often needed by social workers who have theretofore worked only in case work agencies, which provide adequate supervisory help and a favorable atmosphere. The person new to school social work is very much on her own and will value suggestions the authors make.

The chapter on "Social Case Work" quotes from excellent sources, but the presentation is scarcely sufficient and may be confusing to the lay reader or to the teacher who is thrust into school social work without adequate preparation. For the trained social worker the material will be familiar.

Throughout there seems to be, perhaps naturally, an overemphasis on work in Michigan. The description of visiting teacher work would be strengthened by including samples of case records selected from some of the longer established visiting teacher centers. It might also have been more helpful to visiting teachers and more illuminating to class teachers if some of the illustration of case work techniques had been selected from visiting teacher records rather than from agency records.

The chapter on "The Problems of Delinquency" will help to eradi-

cate misconceptions of teachers and laymen and enable them to become more understanding of the needs of children and to see difficult pupils in a new light.

The chapters on "The Problems of Sex" and "The Problems of Alcoholism and Drug Addiction" contain digests of information which all case workers need. These disheartening chapters are followed by a hopeful one describing the function and procedures of the child guidance clinic as a valuable resource for the school social worker and the community in dealing with unadjusted children.

In the last chapter and throughout the book the authors emphasize the service of the case worker in preventing delinquency and serious emotional maladjustments. They focus on the responsibility of the school and also on the cost to society and the individual of not providing preventive services during the school years.

The authors' emphasis on training in social case work is sound, for although understanding and "adoption" of the school as a base of operation and empathy with it are essential for the successful visiting teacher, her basic outlook and skills are those of sound case work.

Each chapter includes a useful list of selected readings and the book is well indexed.

JANE F. CULBERT

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THE HUMAN ANIMAL. By Weston LaBarre. Chicago, University of Chicago Press, 1954. 372 p.

In relatively few pages the author successfully accomplishes the tremendous task of presenting a comprehensive survey of the evolutionary process, from the lowly amoeba to present-day man. Nor is this survey limited to biological evolution. A great deal of its attention focuses upon the origin, growth, and development of social and cultural factors which characterize *homo sapiens*, and the interdependence of cultural and biological traits is explored. The book is intensely stimulating, thought-provoking, and thoroughly fascinating in its global approach to the problem of man's adaptation to his environment, which includes his fellowman.

The innumerable evolutionary changes which have taken place in living organisms throughout the ages have all been the result of imperative need to adjust to survival demands of their environments. No change, no survival. Many of the changes were structural and made possible specialization of function. Man's evolutionary progress, in terms of body structure, culminated in his ability to maintain an upright position, the development of the human hand, hand-eye co-

ordination, and the growth of his brain and nervous system. This made possible his ever-increasing contact with his environment and resultant reality testing. The human hand in combination with the eye and brain ushered in an almost limitless extension of man's capacity to cope with his environment. His potential to invent and develop the tools he needs is boundless. Of infinite significance is the fact that hands are the possession of all human beings. The author also calls our attention to the fact that "physically all the races of man have many times more human traits in common than they have racial traits with relative separateness."

The development of culture is traced to the development of the human family. Without the family there can be no culture, and the larger the group that shares in its experiences the greater is the possibility for cultural development. The nucleus of the human family is the mother, child, and father. Both the father and mother are indispensable for the healthy growth of the human offspring, whose period of infancy and complete dependence is the longest of all primates. It is only in the atmosphere of love, understanding, and acceptance that the healthiest human being can emerge with the greatest capacity for adaptive behavior.

In the chapter dealing with the development of the family and the sexual and social adjustment of members of a group, examples are given of almost every possible variation which could be conceived on a purely theoretical basis. However, the one universal taboo found everywhere among human beings is the prohibition of sex relations between mother and son.

Considerable space is given over to a discussion of language and the development of symbolic systems. Psychosis is explained largely in terms of a breakdown of communication—when the individual evolves his private symbolic system which has meaning only to himself and is no longer capable of reality testing. Schizophrenia is seen as a social disease which is "primarily the result of interference with the deeply rooted and immensely ancient mammalian ties between mother and infant, extravagantly heightened as they are in humans. It is the wrecking of that dependency bond among humans which is necessary to the child's humanity." While one may raise questions about some of the details in the formulation (as, for example, what accounts for the different forms of schizophrenia? At what stage can substitute parents reverse the schizophrenic process? What about the new drugs and the promise they hold out? etc.), the general thesis carries much weight in present thinking.

Finally, the author makes a most eloquent plea for the furtherance of the democratic process as a means to further develop our civilization. It is a plea for continually increasing the social group in order

to achieve the kind of progress which wider and wider participation, global in scope, will make possible. History should teach us that the numerous attempts to impose the will of a few on the many, no matter how benevolent, in a totalitarian form of organization have always resulted in failure and will continue to do so. Democracy alone "permits and fosters mature manhood (and, we may add, womanhood) in all its members."

In his introductory remarks, the author points out that the modern scientific trend is toward integration of all disciplines. He is to be congratulated in having achieved in this book one of the best examples of integration and synthesis in an extremely difficult field.

SIMON H. TULCHIN, M.D.

New York City

DISORDERS OF CHARACTER; PERSISTENT ENURESIS, JUVENILE DELINQUENCY, AND PSYCHOPATHIC PERSONALITY. By Joseph J. Michaels, M.D. Springfield, Charles C Thomas, 1955. 148 p.

The present volume is the result of a series of studies, carried out by the author over a period of 25 years, on the problem of enuresis in its various ramifications and implications. The first six chapters are a condensed recapitulation of twelve papers previously published by the author. These studies are primarily statistical in nature and the interpretations of the data are prevalently descriptive. In the second part of the book broader "bio-psycho-social" interpretations are attempted on a psychoanalytic basis.

In this review only some of the high points of the empirical findings can be reported and for further details the reader would have to resort to the original.

In a study of 475 "normal" children in a summer camp, history of persistent enuresis was found in about one-fourth of the children. (Michaels calls enuresis "persistent" if it occurs at least once a week after the age of three.) Enuresis, nail-biting, thumb-sucking, temper tantrums, and speech impediments were found to occur more often in combination than in isolation, with enuresis as the most significant component of this complex of symptoms. There was also a strong familial factor present: more than twice as many enuretic children came from families where parents or siblings had a history of enuresis than from families without such a history.

The main study was carried out on 1,000 psychiatric patients. Almost one-fifth of the total group had a positive history of enuresis. From all the diagnostic categories by far the highest incidence of a history of enuresis was found among the patients with psychiatric behavior problems, the mentally deficient, and the psychopathic per-

sonalities, while the incidence among psychotics was remarkably low, even considerably less than among normals. Taking instead of incidence the *persistence* of enuresis over ten years of age as a criterion, again the patients with psychiatric behavior problems and the psychopathic personalities were in the lead; the persistence among normals was the least, while psychotics fell in between. Both in regard to incidence and persistence, there is a tendency toward predominance among males.

Besides his own material, Michaels also analyzed and re-evaluated in a series of papers data gathered and published by other authors on delinquent children and psychotic individuals (Healy and Bronner, Drucker and Hexter, Sheldon, etc.). All these data indicate a greater frequency and longer persistence of enuresis in delinquents. Another significant finding was that enuretic children with behavior problems often showed abnormal electroencephalograms, while in children with behavior problems who were not enuretic, such correlation did not exist (Michaels and Secunda).

In the theoretical evaluation of his data the author considers persistent enuresis as indication of a particular form of disturbance of the total personality involving all levels of integration: biological, psychological, and social. He considers the delinquent and psychopathic personality with a history of persistent enuresis as a specific "impulsive type," characterized by an immature, poorly integrated, and disharmonious psychosomatic structure. The common denominator in the impulsive psychopath is a lack of control on all levels. Genetically the most significant factor is "an unchanged perpetuation of an original urethral impulse influencing character formation" (p. 119). These individuals have a weak ego with few defenses and low tolerance for tension and anxiety. The development of the super-ego is grossly impaired.

The presentation of significant data and the thought-provoking theoretical conclusions will recommend this book highly to all those interested in human behavior.

Alice F. Angyal

Boston, Mass.

THE LEARNER FOR THE PROFESSIONS AS SEEN IN EDUCATION FOR SOCIAL WORK. By Charlotte Towle. Chicago, University of Chicago Press, 1954. 432 p.

The social work profession was probably the first outside of psychiatry to be deeply influenced by the theory and practice of psychoanalysis. Significantly, that influence was first exerted through a few schools of social work where as early as 1918 teachers of case work

and of psychiatry joined forces in training psychiatric social workers. The history of that effort has not yet been written, but those of us who were close to the scene of action through a considerable part of the period have a vivid sense of what a long, hard task it was to determine just what were the implications of this new body of knowledge for the practice of social work and the training of social workers.

Charlotte Towle was one of the people close to these developments almost from the start, first as a student, then as a practitioner, and for many years now as one of the leading teachers. In her book she has distilled her long-accumulated knowledge in such a way as to show the contributions of psychiatry fully integrated into the social work curriculum and into the process of training social workers. In fact, she has gone a step further and suggested that much of what has been learned about how to train social workers is applicable to any profession that makes heavy emotional demands on its practitioners.

The questions discussed in the book are central to education for any profession that serves people. How to balance the need to develop high intellectual competence in students and the need to develop their ability to use themselves in service to clients? How do people learn, especially how do they develop a professional self? How can the relation of teacher to student promote this objective? By what criteria should applicants be selected for admission to the school? How is a student's progress in learning to be judged?

The answers to these and other questions spelled out in the book go far beyond the possibility of summarization here. It may be sufficient to say that Miss Towle considers it the obligation of professional education "to impart certain essential knowledge and to conduct educational processes so that they are a means to personality growth" and shows in the book how this obligation can be fulfilled.

HELEN L. WITMER

U. S. Children's Bureau

THE SIX SCHIZOPHRENIAS: REACTION PATTERNS IN CHILDREN AND ADULTS. By Samuel J. Beck. Research Monograph No. 6. New York, American Orthopsychiatric Association, 1954. 238 p.

In 1896, Kraepelin noted a psychiatric syndrome which he called (after Morel) "dementia praecox." Since that time, sixty years ago, scientists have attempted to prove or to destroy that concept. They are still trying to describe and define this "disease," which is now called schizophrenia, as well as to understand its cause and to develop treatments. Beck's book is a spirited attempt to apply scientific method in general, and the Rorschach in particular, to increase our understanding of this riddle which Kraepelin stated but left unanswered.

The book, which has chapters by Grinker and Stephenson, reports an intensive effort to develop a scientific technique which could be used to recognize latent schizophrenia in individuals not necessarily psychotic. It also classifies according to groupings based on personality structure, and estimates the severity of the disorder.

Beck's scientific tool, the Rorschach, is the basic instrument for this task. His problem was to relate what is known about the Rorschach to the clinical symptoms of schizophrenia.

Grinker and his associates provided the essential bridge. They set forth a detailed enumeration of schizophrenic symptomatology classified under defenses, ego disorders, emotional forces, and restitutive forces. Beck and his Rorschach associates then related findings in the Rorschach to particular symptoms on Grinker's list.

Since the symptom list is qualitative and science prefers to quantify, the question was how to reduce the study of personality characteristics to something that could be measured. The Gordian knot was cut by using the relatively recently developed Q-Technique. Professor Stephenson, a Chicago originator of the Q-Technique, transposed Grinker's symptom list to 120 questions. These questions represented characteristics related to schizophrenia. The list included such items as (a) confused illogical thinking, (b) hypersensitive, (c) excessive irritability and 117 others.

A group of twenty schizophrenics were then scored both by the Rorschach and by clinical psychiatrists according to the 120 points. The results were then factored out with a final issue of six clusters of traits. These were the six schizophrenias, each with a specific universe of traits. This is the key to the entire concept.

It is significant that there was agreement between the psychiatrists and psychologists on only three groups, and these were primarily adult schizophrenias.

The first type Beck called S1. It is featured by disturbed thinking. The second he identified as S2, a progressed form of the disease with much fantasy formation. The third, S3, is the most benign but with a marked restriction and inhibition of behavior. To these three the psychologists added two patterns peculiar to children, SP1 and SG. The third, a less malignant adult group resembling S2, was called SR2. Thus with the aid of the Rorschach these six schizophrenias were derived.

The book contains much interesting discussion and speculation about schizophrenia. That "the six schizophrenias" do not correspond with Kraepelinian classification is explained by the fact that the Beck method points out latencies in personality structure. An interesting analogy is made that a draftsman's blueprint looks very different from the finished engine. All patients considered had at least two Rorschach

examinations at least a year apart. This supports the belief that schizophrenic patterns are always changing. For example, the SR1 and SG patterns, found only in children, of necessity change.

What are the conclusions deduced by the author from this work? He feels he has a weapon, based on the concept of a universe of traits, that will recognize schizophrenia, differentiate it into discrete groups, and estimate its severity. He feels this provides useful information for planning treatments as well as starting points for other pertinent researches. He puts great stock in the fact that this pricks the bubble of skepticism as to the practicability of applying science to behavior study.

Beck's concept of schizophrenia will stimulate support in some quarters and opposition in others. For example, he considers that it is not a question of whether schizophrenia or not, but "how much?" The following quotation is his take-off point towards therapeutic optimism, "The person with a schizophrenic adjustment need not be a loss to himself, a burden to his community, if he is aided so as to remain above the psychotic threshold. Let those who are so well integrated that they do not have even a little bit of schizophrenia in them be the first to stand aloof."

The reaction of the reader to this book will depend on his experience and orientation. This reviewer, with a background of clinical psychiatry, and very limited experience with the Rorschach, found the volume stimulating and informative. He felt the book might have been a little easier to read with one more chart of the 120 traits, listed in the order of their "official" numbers. He felt that both Beck and Stephenson were too defensive in regard to anticipated criticism. Understandably, many will question the validity of conclusions from such a limited number of subjects, and the use of the unfamiliar Q-Technique in transposing qualitative to quantitative factors. However, the book is well written and should be profitable and stimulating to all those who, regardless of orientation, are interested in advancing the state of our knowledge of schizophrenia.

D. GRIFFITH MCKERRACHER, M.D.

University of Saskatchewan

NOTES AND COMMENTS

WEST ORGANIZES REGIONAL ATTACK ON MENTAL ILLNESS

Eleven western states and Alaska have laid the groundwork for a sweeping expansion of mental health facilities, training and research west of the Rockies. After a year-long inventory of the region's problems—and resources—in handling the mentally ill, they have filed with the Western Interstate Commission for Higher Education a 154-page report calling for:

- Wider use of general hospitals in caring for the mentally ill.
- Sponsorship by mental health associations of more educational programs for welfare, probation and health workers, physicians, clergymen and lawyers, whose work brings them into early contact with many of the emotionally disturbed.
- Concentration by mental hospital administrators on increasing the number, pay, training and prestige of psychiatric aides.
- Subsidies to attract recruits to mental health training programs.
- Improved communications in the mental health field, especially between state mental hospitals on the one hand and local physicians and agencies on the other.
- Designation of one staff member as research director in each western mental hospital and university, no matter how small or isolated, to encourage research, advise on specific research problems and seek subsidies for new and continuing projects.
- Long-range plans for training mental health personnel, on the theory that training programs must operate several years for their effects to be felt.

The investigation, requested by the Western Regional Conference of the Council of State Governments, involved thousands of westerners. Almost 300—legislators, professional workers and prominent laymen—served on state survey committees. Their recommendations reflect the ideas of another 7,000 who responded to detailed questionnaires about training, research, prevention and organization.

An \$80,000 grant from the National Institute of Mental Health financed the exhaustive study, sponsored by the Western Interstate Commission for Higher Education.

In their report the survey committees asked the WICHE to serve as a regional clearing house for information on research projects, en-

courage training and research that will develop community resources for preventing and treating mental illness, and study the feasibility of interstate and regional mental health programs. The report includes detailed analyses of the mental illness problem in Alaska, Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Wyoming and Washington.

The inventory disclosed that the West has 26 state mental hospitals, 14 state institutions for the mentally deficient, 7 neuropsychiatric hospitals operated by the Veterans Administration, and 117 mental hygiene clinics. But, the report pointed out, only 4 of the 11 states have mental hospitals approved for training psychiatrists, only 3 have hospitals that train clinical psychologists, only 2 have hospitals that offer social work training and advanced psychiatric training for nurses.

With more than 64,000 patients in state hospitals alone, the region has fewer than 5,000 mental health workers—1,147 psychiatrists, 867 psychologists, 784 social workers, 1,471 nurses, and 471 rehabilitation therapists—spread among more than 150 institutions and clinics. The report emphasized that the shortage of professional personnel hampers treatment, particularly in the state hospitals. (Though these hospitals have 85% of the patients, they have only a third as many psychiatrists and social workers, a fourth as many psychologists and a seventh as many nurses as the VA hospitals.)

The survey committees urged the expansion of training opportunities for psychiatric personnel and pointed to the need for more and better training centers, regional workshops, seminars and other educational exchanges. Their report also recommended recruiting across state lines, interstate loans of personnel, and stronger ties between the universities which train psychiatric personnel and the understaffed mental hospitals.

Though 883 research studies relating to mental illness are moving ahead in western laboratories, investigators found that lack of time, money and encouragement from their superiors have forced scientists to shelve plans for three times that many research projects.

The inventory revealed that community mental health services are also suffering because of the personnel shortage. The West's social agencies, dealing regularly with problems of emotional maladjustment, need many psychiatric social workers. With 10% to 15% of their students requiring specialized help, the schools too—though short of funds and public support—must compete for the region's all too few mental health specialists.

APA URGES CAUTION IN USE OF DRUGS

The American Psychiatric Association has released a statement praising tranquilizing drugs but cautioning against their casual use for the relief of everyday tensions. Noting a report that 3 of the 10 compounds most frequently prescribed last year were tranquilizers, the APA's committees on research, therapy, and public information pointed out that the drugs have not been in use long enough for thorough evaluation of their side effects.

Excerpts from the APA statement follow:

"The profession of psychiatry recognizes with enthusiasm the development of the tranquilizing and other drugs for the treatment of psychiatric disorders over the past four years. The evidence is that these drugs are effective in making disturbed patients in mental hospitals more readily accessible to treatment. This has made possible impressive advances in mental hospital treatment programs and increased discharge rates. Further, by making patients more comfortable, the drugs have contributed greatly to improving the atmosphere and the management of mental hospitals. It seems clear also that the drugs are useful adjuncts in the psychiatric treatment of certain patients in private practice and on an outpatient basis in clinics and hospitals, though the extent and the conditions under which this practice will prove sound remain to be confirmed through prolonged and careful study.

"Psychiatrists are at the same time concerned about the apparently widespread use of the drugs by the public for the relief of common anxiety, emotional upsets, nervousness, and the routine tensions of everyday living.

"Casual use of the drugs in this manner is medically unsound and constitutes a public danger. The tranquilizing drugs have not been in use long enough to determine the full range, duration, and medical significance of their side effects. Use of these drugs is no more to be encouraged than use of any other drug except where proper medical diagnosis determines that a drug is indicated to maintain the life and functioning of a person."

Other mental health leaders also urged this fall that physicians and researchers pay more attention to the bad effects tranquilizing drugs might have on man's brain and behavior. Nearly 700 experts met in Washington September 21-22 to map plans for an intensive research effort to learn more about the tranquilizers.

They called for the establishment of minimum standards of safety and effectiveness to screen drugs for clinical trials and eventual use

by the general public. Their recommendations grew out of discussions at the first national conference on the evaluation of drug therapy in mental illness.

JOINT COMMISSION RECEIVES \$25,000 GRANT

Dr. Jack R. Ewalt, study director of the Joint Commission on Mental Illness and Health, announced receipt June 24 of the first substantial grant from a private source in support of the three-year national mental health study begun by the Commission earlier this year. The grant came from the Smith, Kline and French Foundation of Philadelphia for general support of the Commission's work in appraising present mental health knowledge and methods, pointing out gaps, limitations and deficiencies, and finding new approaches to solving the mental illness problem or better ways of implementing existing methods.

The study was undertaken under a 1955 Act of Congress authorizing the National Institute of Mental Health to grant \$1,250,000 over a three-year period for an independent, objective, thoroughgoing survey. The act provided that the Joint Commission—organized for the purpose by a score or more of national organizations—can accept additional support from non-governmental sources.

"The Smith, Kline and French grant," said Dr. Ewalt, "is the first of perhaps as much as \$2,500,000 that we should like to raise from private foundations or industrial sources as a supplement to government funds.

"The study staff and its various advisory committees, made up of leaders in the mental health field, have completed the overall study design. The first task forces are now functioning. One is concerned with how mental health is promoted in the schools, the other with what happens to mental patients from the point of their breakdown in the community until their rehabilitation, when and if this occurs."

WORK TO HALT JAILING OF MENTALLY ILL

In a formal resolution passed at their annual convention in Akron last June, the National Sheriffs' Association urged "abolishment of the county jail as a temporary detention facility for the mentally ill." The resolution follows:

WHEREAS, the sheriffs of the nation have repeatedly expressed disapproval of use of the county jail for temporary detention of the mentally ill, and

WHEREAS, there has been no widespread decrease in the practice in the past year, therefore

BE IT RESOLVED, that the sheriffs restate their reasons for requesting county and general hospitals to accept these patients:

1. The mentally ill person has usually committed no crime.
2. County jails today are overcrowded.
3. Small county sheriffs' officers are not specially trained for the proper handling and care of a mental patient.
4. Many jails do not have proper or adequate detention rooms for the mentally ill.
5. Detention in the county jail is unfair to the patient as well as to the custodians.
6. Psychiatrists agree that a patient originally detained in a county jail is much more difficult to treat and readjust.
7. Many mentally ill have committed suicide while detained in county jails.
8. It is the duty of constituted public agencies to provide hospital detention facilities for the mentally ill.

The sheriffs sent copies of the resolution to the National Association of County Officials, American Public Health Association, U. S. Public Health Service, Association of State and Territorial Health Officers, American Association for Hospital Planning, National Institute of Mental Health, Council of State Governments and National Association for Mental Health.

* * *

The 84th Congress adopted a good deal of mental health legislation:

- A \$35,197,000 appropriation—\$17,196,000 more than last year—for the National Institute of Mental Health. This amount allows \$2,000,000 for testing new drugs, \$12,246,000 for training psychiatric personnel, \$500,000 for the massive mental health survey of the Joint Commission on Mental Illness and Health, \$1,500,000 for federal grants to state mental hospitals for investigations, experiments and demonstrations designed to improve the care and treatment of patients, and \$3,000,000 for grants to states for detection, diagnosis and other preventive and control services. Mental health associations throughout the country supported the amendment of Rep. John Fogarty of Rhode Island adding \$13,448,000 to the sum recommended for NIMH by the administration.
- A \$675,000 increase for the U. S. Office of Education for research on educational problems of the mentally retarded.
- A \$2,000,000 appropriation for the Office of Vocational Rehabilitation for grants to nonprofit organizations for special projects (such

as a demonstration of ways of providing psychiatric treatment to the deaf or an analysis of the work potentialities of mentally retarded adolescents).

- A \$10,000,000 appropriation for the Veterans Administration for expanded medical research on mental, nervous and brain disorders and other major diseases.
- Authorization for Alaska to establish its own mental health program using up to \$6,000,000 for operations and up to \$6,500,000 for the construction of one or more hospitals. (For more than 50 years Alaska mental patients have been committed to a private hospital in Portland, Ore.)

* * *

EXTEND BENEFITS TO MENTAL PATIENTS

Oklahoma's Blue Cross and Blue Shield plans have approved hospital and medical care benefits for members suffering mental and nervous illnesses.

Last July 1, emotionally ill Blue Cross members became entitled to up to 30 days of hospital care during any 12 months. Hospitalized psychiatric patients who are members of Blue Shield became entitled to benefits for their physicians' visits. Medical care benefits begin the fourth day of hospitalization and cover a maximum of 27 days' care during any 12 months.

N. D. Helland, Oklahoma Mental Health Association board member, said the Blue Cross and Blue Shield approved the new benefits in answer to general public demand throughout the state. Psychiatrists predict the extension of benefits to the mentally ill will spur the establishment of psychiatric units in Oklahoma's general hospitals, allow many patients to get early treatment and eventually take some of the load off the crowded state hospitals.

* * *

Texans voted favorably this fall on a proposition to amend the state constitution so that jury trials for indefinite commitment of mental patients to state hospitals may be waived. Texas was the only state requiring that the mentally ill face trial by jury before they could receive care in public hospitals.

* * *

BOARD RECOMMENDS SIX MHA SERVICES

The board of the National Association of Mental Health has approved a list of six services that mental health associations may provide to hospitals and communities: information service, volunteer

service to psychiatric patients, assistance to families of patients, assistance in the vocational and social rehabilitation of discharged patients, educational programs for community groups, and public information programs.

The board has also authorized pilot studies of these services in 5 to 10 areas where they do not yet exist, so that after a period of guidance, observation and evaluation operational standards can be set.

In other action the board has reiterated NAMH concern for the mentally retarded and considered ways of working more closely with the American Association on Mental Deficiency and the National Association for Retarded Children; approved an increase in the NAMH grant to the American Psychiatric Association for the inspection and rating of public mental hospitals; noted that clubs composed of former mental patients are springing up in some communities and recommended that mental health associations work only with those under their own direction and sponsorship; and hailed the news that six state and territorial mental health associations—those in Arkansas, Missouri, New Mexico, North Carolina, West Virginia and Wyoming—are completing the process of becoming NAMH divisions.

* * *

FOUR SERVICE GROUPS BACK MENTAL HEALTH

Four men's service organizations with millions of members from one coast to the other have adopted mental health as a project and called their local units to active participation in the fight against mental illness.

Meeting in San Francisco last summer, Kiwanis International for the second time urged its clubs and members to help:

- Create a better public understanding of the causes, prevention and cure of mental illness.
- Plan and provide adequate research, treatment facilities and trained personnel to restore mental patients to good health.

The same month Civilian International, convening in Boston, adopted mental health as a project, and Optimist International, convening in Los Angeles, urged each Optimist Club to become actively interested in the mental illness problem and volunteer its services to the local mental health association.

A few weeks later in St. Paul Unico National followed suit.

* * *

An 18-month experiment at Agnews State Hospital near Santa Clara, Calif., shows that some types of mental illness, including schizophrenia, are influenced by TV therapy. Closed-circuit TV therapy

simulates face-to-face situations and gives the impression of some aspects of individual therapy even while being administered to a large group. The hospital's psychiatrists, who could give an average of six minutes of therapy a day to a patient in person, find they can give much more time to patients with the help of the TV screen.

The experimental group saw 217 special films, chosen to spur their interest in recovery and in adjusting to life outside the hospital. Live shows originating in the hospital also helped. Programs included psychodramas, art and music, and quiz shows.

• • •

CANADA'S SERVICES CALLED INADEQUATE

The Canadian Mental Health Association has called for large-scale development of mental health services and facilities in all parts of the dominion "since present services are inadequate for either hospitalization or community care."

Convinced that modern psychiatric diagnosis and treatment require radical changes in the structure, organization and administration of mental hospitals, the association has recommended that no more large mental hospitals (or additions to those now in operation) be built. It urges instead regional mental hospitals of not more than 400 to 500 beds, located near medical schools and tailored to regional needs and circumstances.

Arguing that a community is not well served by piecemeal, unrelated development of individual facilities, the association wants an interlocking pattern of mental health services: mental hospital, social agencies, clinics, the psychiatric ward of the general hospital, private practitioners and medical school. It has also called for a census of mental illness to learn what kind of mental health services are in demand, and where.

• • •

BROADEN VOLUNTEER SERVICES

A new service of the National Association for Mental Health got underway this fall with the appointment of Miss Mary Mackin as Administrative Assistant Director of Volunteer Services. She will aid a volunteer Director in guiding and extending voluntary participation in the mental health movement.

"Working through the NAMH field staff, as do all services of the national office, the new service will assist state associations, and through them local associations, in expanding their volunteer services," Richard P. Swigart, NAMH executive director, explained. "We are particularly

interested in helping them achieve sound methods of recruiting, training and guiding volunteers for service on mental health association boards and committees, for service to patients in mental hospitals and clinics, to discharged patients and to the families of patients, for educational service as discussion leaders, and for varied clerical duties in mental health association offices."

Miss Mackin has had wide experience, both local and national, in organizing and developing volunteer services. During 12 years with the American Red Cross she worked in military hospitals overseas, in the VA neuropsychiatric hospital at Topeka and at Hines VA hospital, Chicago, and was an assistant director of the national ARC Office of Volunteers.

* * *

ASK IMPROVED CARE FOR THE RETARDED

Official representatives of 10 northeastern states have called on the Council of State Governments to stimulate improved care for the mentally retarded. They also asked the Association of State and Territorial Health Officers to weigh the need for additional federal funds to provide proper facilities for retarded and emotionally disturbed children.

At their fourth semi-annual meeting, held in Providence this fall, the Northeast State Governments Conference on Mental Health urged in a formal resolution that a CSG committee of professional workers, legislators, government officials and laymen:

- Develop a model act covering the legal and organizational aspects of care and treatment for the mentally retarded.
- Develop guides for services to all kinds of mentally retarded children and adults.
- Stimulate and possibly sponsor research and training in the field of mental retardation.
- Consider methods of coordinating the activities of federal, state and local agencies involved in research, training and treatment for the mentally retarded.

Continuing discussions begun last spring, those participating in the conference concluded that children who are mentally ill should receive care and treatment in or near their own community. They also agreed that institutions for mentally ill children should be coordinated with local agencies.

"There is some tendency," a spokesman pointed out, "for local agencies to cut themselves off from any responsibility for a child once it has been placed in a state institution. It is sometimes too easy for

them to 'dump' a child on the institution and too difficult to get the child back into the community."

In another resolution the states agreed to ask the Surgeon General of the U. S. Public Health Service to "study and consider the question of a major increase in funds" for community mental health services throughout the country. They also pointed to the continuing need for adequate professional training for mental health workers, both before and during their service.

Recommendations and resolutions adopted by the fourth conference are available from the Council of State Governments, along with the proceedings of the third conference, held last spring at Asbury Park, N. J.

* * *

Three universities have received grants totaling \$425,893 from the National Institute of Mental Health to develop mental health studies for theological students.

Harvard University, Yeshiva University, and Loyola University in Chicago will use the funds during the next five years for pilot and evaluation projects designed to give future clergymen mental health insights necessary to the successful discharge of pastoral functions. Frequently, it was pointed out, the trained clergymen can perform an important service by referring the emotionally disturbed to sources of psychiatric help.

The Harvard project will enlist the support of the American Association of Theological Schools, Loyola will cooperate with Catholic seminars, and Yeshiva will establish ties with Jewish seminars and colleges representing the different branches of Judaism. The new National Academy of Religion and Mental Health assisted in developing the program and will serve as consultant.

* * *

Columbia University has instituted a 20-month degree course in psychiatric administration to prepare candidates for posts in mental hospitals, clinics and community mental health programs. Each student divides his time among basic courses leading to a master of science degree in administrative medicine, specialty courses in the department of psychiatry, supervised field observation in an institution or community program, and a special project.

LESTER TAYLOR MEMORIAL SCHOLARSHIP

A \$500 scholarship, named for the Cleveland Health Museum's first president, has been made available by the women's committee of the museum to any qualified graduate student interested in school

health education, visual methods in health education or educational work in museums.

Special projects, tailored to the interests and requirements of the candidate, are set up for completion in from one to three months. All projects must be completed on the museum premises under the direction and supervision of its professional staff, and a written report of the project(s) is required.

A tuition fee of \$100 will be paid to the museum from the \$500 stipend. The remainder is paid directly to the candidate for living and other expenses.

Address all requests for applications to Bruno Gebhard, M.D., director, Cleveland Health Museum, 8911 Euclid, Cleveland 6, Ohio.

* * *

The Hofheimer Prize of \$1,500 is awarded annually by the American Psychiatric Association for an outstanding research contribution in the field of psychiatry or mental hygiene which has been published within three years of the date of the award. The competition is open to citizens of the United States and Canada not over forty years of age at the time the article was submitted for publication, or to a group whose median ages do not exceed forty years of age. The next award will be made at the annual meeting of the American Psychiatric Association in May, 1957. Articles submitted to the Prize Board before March 1, 1957 will be considered. Eight copies of each publication and data concerning age and citizenship should be sent to Theodore Lidz, M.D., chairman, Hofheimer Prize Board, 333 Cedar St., New Haven, Conn.

SIGNIFICANT PUBLICATIONS

Psychiatry, the Press and the Public is a provocative discussion of problems encountered in communicating psychiatric information to the public. The 66-page booklet summarizes ideas developed by eminent psychiatrists and the nation's leading science writers and reporters during a conference called last year by the American Psychiatric Association in cooperation with the National Association of Science Writers and the Nieman Foundation for Journalism.

More than 50 of them met to talk over some hitherto unpublished findings about public attitudes towards psychiatry and mental illness, and consider how psychiatry and the press can work together more effectively in breaking down misconceptions about mental disease.

Though the codes of their two professions frequently impede rather than facilitate teamwork, both the psychiatrists and the writers were able to agree on four general principles:

- The two professions have a joint objective of giving the public accurate information that will further its understanding of psychi-

atry and promote the public's acceptance of its responsibility in meeting the problems of mental illness.

- In attaining this objective, psychiatrists can serve as reliable sources of information and members of the press can give this information thoughtful presentation.
- Responsible members of both professions will avoid distortion and sensationalism, try to remove the stigma associated with mental illness, and keep in mind that some psychiatric material may arouse anxiety. Above all, they must be concerned with the welfare of the patient and the protection of his interests.
- Members of each group should deal with those of the other group as professional persons with appropriate skills, who function under restrictions imposed by their own discipline.

* * *

Almost 80 recent films are listed in *Mental Health Motion Pictures*, 1956 supplement to a selective guide released four years ago by the National Institute of Mental Health.

The new list contains information on 11 films which help people understand themselves and children, 4 which can be used in marriage counseling, 8 which help teachers increase their understanding of students and their problems, 16 for use in classrooms to help students understand emotional problems, 28 which give general audiences a better understanding of mental illness, and 11 with other mental health implications.

A special virtue of the supplement is that it provides space in which to record the opinions of groups previewing each film. Information on each entry includes: producer, distributor, year produced, suggested audiences, television information and a short description of the content.

The list is available for 30¢ from the National Association for Mental Health, 10 Columbus Circle, New York 19.

* * *

Considerable information of use to mental health associations appears in a new publication called *Programs on Alcoholism Research, Treatment and Rehabilitation in the United States and Canada*. The 36-page analysis contains state-by-state figures on treatment and treatment facilities, follow-up, education and information, and research. Both a handbook of information and a guide for public action, the book gives a good picture of the way each state goes about helping the alcoholic. It is a publication of the Licensed Beverage Industries, 155 E. 44th St., New York 17.

* * *

Most of the important books and articles about the mental health of college students in the last 20 years are listed and in many instances abstracted in a bibliography released this fall. The World Federation for Mental Health and the International Association of Universities published the list of 1800 references especially for an international conference on student mental health held in Princeton, N. J., September 5-15.

In a foreword Dr. Daniel H. Funkenstein and George H. Wilkie, who prepared the bibliography, observe that a mental health program for college students benefits the general population as well as the students and faculty.

Student Mental Health: An Annotated Bibliography, 1936-1955 abstracts many articles that appeared in MENTAL HYGIENE. The bibliography is available for \$3 from the New York office of the World Federation for Mental Health, Room 1300, 10 Columbus Circle.

* * *

Mental hospital employees in some states are working as many as 55, 60, 66 and 72 hours a week. Graduate nurses in North Carolina's mental institutions work 66 hours a week. Members of the medical staff of an Iowa institution work 55 hours plus night calls. Supervisors and attendants in Tennessee's institutions work 72 hours.

These are some of the findings reported recently by the Interstate Clearing House on Mental Health in *Selected Employment Regulations for Personnel at State Institutions for the Mentally Ill and Mentally Deficient*. The 39-page report tabulates information on working hours, work week, compensation for overtime, vacation and sick leave privileges, merit and retirement system coverage for public mental institutions in the 48 states.

Institutions in all but four states—Arkansas, Idaho, Missouri and West Virginia—provide some kind of retirement system for their employees, and more than half the states operate a merit system for some classes of institution workers.

If you want to compare working conditions for institution employees in your state with those elsewhere, send \$1.50 to the Council of State Governments, 1313 E. 60th St., Chicago 37, for a copy of the report.

* * *

Who is delinquent? asks Dr. Fritz Redl in the title of a recent article in the *National Parent-Teacher Magazine* in which he presents his own interpretation of the problem. The author, chief of the NIMH laboratory for child research, expresses impatience with those who unthinkingly brand any and all aspects of Johnny's defiant conduct as "delinquent." This stereotyped tendency to lump all defiant conduct under a convenient label reflects, says Dr. Redl, a regrettable lack

of discernment and understanding of youthful problem behavior. Dr. Redl, who is well-known for his writings and lectures in this specialized field, takes a dim view of the fuzziness and lack of precision that characterize popular usage of the term "delinquency." He feels such generalizations, entirely unsupported by scientific findings, obscure the problem and hamstring a broad approach to corrective planning.

* * *

More and more law enforcement officials are building their training courses for rookie policemen around a manual, "How to Recognize and Handle Abnormal People," published by the National Association for Mental Health. From one end of the country to the other, they comment enthusiastically on its value as a training tool.

After using the manual as a text for a 4-hour course, 60 police recruits of Miami, Fla., asked for a longer course next year. The Mental Health Society of Southeast Florida supplied the Police Academy with copies of the booklet.

The Connecticut Association for Mental Health has distributed about 1,000 copies to the FBI, State Police and others. The New Haven Police Academy asked the CAMH to conduct a 2-hour session for the benefit of recruits, and to provide a discussion leader for two training sessions for police officers.

The Delaware Association for Mental Health has also embarked on an intensive training series for the State Police, with discussions by a psychiatrist, a psychologist and a psychiatric social worker of topics in the manual. And the Texas Society for Mental Health has reported that Galveston police used the booklet to good advantage in a 3-day course, with San Antonio planning to follow suit.

* * *

A new serial format distinguishes the latest edition of the NIMH's *Annual Report of Patients in Mental Institutions* which this year contains data based on the 1952 annual census of patients. Heretofore this annual compilation, prepared in the NIMH's biometrics branch, has appeared as a single volume. Commencing this year, the work will be released serially in four segments . . . Part I: *Public Institutions for Mental Defectives and Epileptics*, can be obtained from the Superintendent of Documents, Washington 25, D. C., for 35 cents a copy. Specify Public Health Service Publication No. 483—Part I. Announcement will be made in MENTAL HYGIENE as each of the three remaining parts are published.

HONORED FOR CONTRIBUTIONS TO MENTAL HEALTH FIELD

With a gift of \$400,000 from the Ittleson Family Foundation, the Washington University School of Medicine, St. Louis, has established

the Blanche F. Ittleson chair of child psychiatry, first such endowed professorship in the United States. Mrs. Ittleson, one of the country's pioneers in the field of mental health, has worked for 40 years to establish programs that would develop the mental, psychological and emotional health of children and adults.

NEW APPOINTMENTS IN NEW YORK DEPARTMENT

Robert E. Patton has been appointed director of the bureau of statistics in the New York State Department of Mental Hygiene. He succeeds Benjamin Malzberg, Ph.D., who resigned in September to carry out a five-year research project on demographic and related aspects of mental disease.

Dr. Alvin I. Goldfarb has been named consultant on psychiatric services for the aged. In the new position, created by the 1956 legislature, he will coordinate geriatric programs and help in planning for aged mental patients.

SEVENTH LECTURE SERIES

The North Shore Health Resort, Winnetka, Ill., launches its seventh annual lecture series this fall with Dr. Daniel Blain, medical director of the American Psychiatric Association discussing "The Unique Position of the Physician in Our Society." The 1956-57 series of nine lectures will highlight the role of the physician as a counselor in promoting healthy emotional development. They will be presented as a public service to acquaint doctors, medical students, the press and allied professional personnel with the problems, techniques and management of psychiatric cases.

Previous series were edited by Dr. Samuel Liebman, the hospital's medical director, and published by J. B. Lippincott & Co. in two books, "Stress Situations" and "Management of Emotional Problems in Medical Practice." The forthcoming series will also be published as a monograph, with royalties going to the American Psychiatric Association for the promotion of public education in mental health.

NEW PERIODICAL

On its way to a stable position among mental health periodicals is the *Archives of Criminal Psychodynamics*, now completing its first year. Dr. Ben Karpman is editor, Dr. Melitta Schmideberg associate. The editorial board includes Drs. Walter Bromberg, Jacob H. Conn, George Devereux, Wladimir G. Eliasberg, Arthur N. Foxe, George E. Gardner, Leo Kanner, Samuel B. Kutash, Lawson G. Lowrey, Sydney

B. Maughs, Karl A. Menninger, Lester W. Sontag, Karpman and Schmideberg. The address is Station L, Washington 20, D. C.

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The editorial office of MENTAL HYGIENE moved the end of October to Room 1300 in the New York Coliseum at 10 Columbus Circle, New York 19. The new telephone number is PLaza 7-7800.

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